VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Battle Creek VA Medical Center

5500 Armstrong Road
Battle Creek, MI 49037
www.battlecreek.va.gov

In Reply Refer To: 515-012GR

February 1, 2017

Mr. James Redford, Director
Michigan Veterans Affairs Agency
222 North Washington Square
Phoenix Building 5th Floor
Lansing, MI 48933

Dear Director Redford:

Please find the enclosed full certification letter from the for cause survey conducted at Grand Rapids Home for Veterans on November 15-18, 2016.

Congratulations to you and your staff on attaining full certification.

If you have any questions, please contact me at 616-249-5373.

Sincerely,

Susan Honaker
Acting Director, Wyoming VA Health Care Center

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Battle Creek VA Medical Center

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Battle Creek, MI 49037
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In Reply Refer To: 515-012GR

January 31, 2017

Mr. Steven Rolston, Interim Chief Operating Officer
Grand Rapids Home for Veterans
3000 Monroe Ave NE
Grand Rapids, MI 49505

Dear Mr. Rolston:

The Battle Creek VA Medical Center survey team conducted the for cause survey of the Grand Rapids Home for Veterans and Domiciliary on November 15-18, 2016. There were deficiencies cited that you were notified of in a letter dated December 15, 2016.

The Corrective Action Plan you submitted on December 22, 2016, has been accepted and completed. I find the Grand Rapids Home for Veterans in compliance with all VA standards. Your facility is now granted a full certification until your next annual survey. Thank you for your continued support of our nation's Veterans.

If you have any questions, please contact Lisa Martin, VA Medical Center Representative, who coordinates the VA survey team's activities at 616-249-5374.

Sincerely,

MARY BETH SKUPIEN, Ph.D.
Medical Center Director

cc: Mr. James Redford, Director, Michigan Veteran Affairs Agency
cc: Mr. Robert McDivitt, VISN 10 Network Director
cc: Chief Consultant, Geriatrics and Extended Care (10P4G)

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
17	5. Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monitary compensation. The individual must complete a new training and competency evaluation program. 6. Regular in-service education. The facility management must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must; i. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; ii. Address areas of weakness as determined in nurse aide's performance reviews and may address the special needs of residents as determined by the facility staff; and iii. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	(P) Provisional Met	Performance reviews did not occur every 12 months. No tracking system for 12 hours of annual training was in place. Specialized training had been discontinued for assignment to the secure unit as well as providing care for the cognitively impaired. Suggestions were provided by team members on developing a spreadsheet for documenting and tracking training. S/S=E	<insert CAP details here>			
18	I. Proficiency of nurse aides. The facility management must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	(M) Met					

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26	p. Quality assessment and assurance. 1. Facility management must maintain a quality assessment and assurance committee consisting of: i. The director of nursing services; ii. A primary physician designated by the facility; and iii. At least three other members of the facility's staff.	(M) Met					
27	2. The quality assessment and assurance committee: i. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and ii. Develops and implements appropriate plans of action to correct identified quality deficiencies; and	(P) Provisional Met	While quality measure deficiencies were identified and recorded in the Quality Committee meeting minutes, there is no evidence of follow through to correct said deficiencies. S/S=E	<insert CAP details here>			
28	3. Identified quality deficiencies are corrected within an established time period.	(N) Not Met	Not all deficiencies were corrected within 45 days and there were no interim corrective action plans developed and implemented for deficiencies that could not be corrected within the required time frame. S/S=F	<insert CAP details here>			
29	q. Disaster and emergency preparedness. 1. The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.	(M) Met					
30	2. The facility management must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	(P) Provisional Met	Although the Safety Officer had thorough documentation of training and drills, a sense of urgency and full participation/action in drills were lacking by unit staff members and could result in widespread harm in the event of an actual fire. Additional training of staff was completed while the survey team was on site. It should be noted that the Acting Director of Nursing (DON) and Assistant Directors of Nursing were fully engaged and performed admirably during the unannounced drill. S/S=E	<insert CAP details here>			

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36	§ 51.70 Resident Rights The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights. a. Exercise of rights. 1. The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights. 3. The resident has the right to freedom from chemical or physical restraint. 4. In the case of a resident determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. 5. In the case of a resident who has not been determined incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.	(P) Provisional Met	Based on observation, interview, record review, and facility policy it was determined the facility failed to protect and promote the rights for two (2) of 30 sampled residents, Residents # 15 and #16. The facility had placed a spending restriction on Resident #15's money without evidence as to why the spending restriction was in placed. Resident #16 had been residing in the secured behavior unit for six (6) years. According to the resident's Care Plan the resident had behaviors of inappropriate touching, and per staff for talking to himself/herself. Resident #16's Care Plan goal to address behaviors was for the resident to display appropriate behaviors 100% of the time. Review of Resident #16's behaviors for the previous four (4) months revealed the resident had two (2) documented incidents of talking to himself, "to the Lord," and to his/her deceased father, no incidents of inappropriate touching. There was no other evidence in record to support the need for Resident #16 to reside in a secured behavior unit. The findings include: 1. Review of Resident #15's clinical record revealed the resident was admitted to the facility on 10/26/04. The resident's diagnoses included Bipolar Disorder, Schizophrenia, Chronic Hepatitis C, Hypertension and Chronic Obstructive Pulmonary Disease. Review of the quarterly Minimum Data Set Assessment (MDS) dated 02/27/16 revealed the resident's cognitive status was intact with no mood or behavior symptoms present during the assessment period. According to the Minimum Data Set (MDS) assessment the resident required supervision with meals, minimal assistance with bed mobility and required extensive assistance with transfers, mobility, dressing, personal hygiene, bathing and toilet use. Resident # 15 was observed on 04/19/16 at 2:50pm sitting in a wheelchair in the dayroom/dining room on the behavior unit. The resident was	<insert CAP details here>			

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			drinking fluids from a cup and appeared to be actively listening to a crossword activity conducted by the unit activity director. On 04/20/16 at 9:00am a staff person from the business office came to the secured behavior unit with a drawer with money and sat at a table in the dining room/dayroom area. The residents on the unit began lining up and received money from the staff person. When the surveyor asked the nurse what the residents were doing, the nurse replied, "They're locked up here. Every Wednesday they can get money from their bank account." Further observations of Resident #15 on 04/21/16 at 9:15am and on 04/22/16 at 10:30am revealed the resident was sitting in a wheelchair in hallway of the secured behavior unit. The resident said to staff passing by, "I want my money I won playing Blackjack. I won $7.00." (The facility had a casino day on 04/20/16.) The Unit Manager (UM) informed the resident on 04/22/16 at 10:30am, his/her money was placed in the facility's bank and that he/she would have to wait until Wednesday, five (5) days for the money. The UM continued to inform surveyor Resident #15 had a restriction on his/her money and perhaps was unable to retrieve the money he/she had won playing blackjack. The UM said the resident was not making good choices with budgeting money and a spending restriction had been placed on the resident's account at the facility. Review of Resident #15's Care Plan and Interdisciplinary Progress Notes 01/01/16-04/22/16 revealed a care plan for spending restriction had not been developed and there was no evidence in the record a spending restriction had been discussed with the resident and/or resident's family. An interview with a Social Worker on 04/22/16 at 10:00am revealed he/she had reviewed Resident #15's record and could find no evidence the staff had determined Resident #15 needed a			

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			spending restriction on his/her money. However, during interview with a finance officer on 04/22/16 at 10:30 it was determined another Social Worker had contacted the business office on 11/12/15 and placed a spending restriction on Resident #15's account, $15.00 a month for haircut and the unit to order one (1) carton of cigarettes per month. Review of resident's balance on 04/22/16 revealed the resident had $264.45 in his/her account at the facility. Review of the "Member Guide Book," updated August 2014 revealed the facility will ensure all members have the right to a dignified existence and self-determination. The facility will protect and promote the rights of each member. Personal Funds: You are encouraged to maintain only a minimum amount of money in your possession at any time. You can deposit funds into your account at the facility's bank. The facility Bank is open from 10:00am until 12:00pm during regular State business hours. 2. Review of the facility policy, "Main Courtyard Criteria," dated 05/27/15, revealed the Main Courtyard is a locked special needs unit which provides 24 hours support and care to residents with a need for a calm, structured environment. Residents who required protection and safety of a secured unit may include those at risk of harming themselves or others and those with elopement risk. The goal of the treatment is to ensure that residents are placed in the least restrictive environment that allows him/her to function at his/her highest quality of life. Weekly team meetings are conducted and include discussion and documentation of progress made with residents behaviors. This will also include assessment for transfer to an open unit. Resident #16 was observed on 04/21/16 at 10:15am in the dayroom/dining room area of the secured behavior unit with a songbook in hand singing religious songs with				

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			other residents and a volunteer. A further observation on 04/22/16 at 10:10am revealed the resident was sitting in the dayroom/dining room of the secured behavior unit watching a Western movie on TV. The resident smiled when he/she was spoken to and replied to with a smile to any question asked, "Everything is just fine." Review of Resident #16's clinical record revealed the 63 year old resident was admitted to the facility and to the secured behavior unit of the facility on 01/06/10. The resident's diagnoses included Korsakoff's Dementia, History of Alcohol Abuse, Hypertension, Depression and Persistent Delusions. Review of the quarterly MDS Assessment dated 04/06/16 revealed the resident was assessed to have moderately impaired cognitive status, had exhibited no behaviors during the assessment period, required no assistance/supervision with bed mobility, transfers or ambulation, required supervision only with meals, required one (1) person physical assistance with dressing and toilet use, and required two (2) person physical assistance with bathing and hygiene. Resident #16's Care Plan with revision date of 02/05/16 stated a Care Plan Problem included the resident had memory deficits due to Korsakoff's dementia and the resident benefits from the controlled structured environment of the secured behavior unit. The resident can present with inappropriate behaviors at times, such as inappropriate touching. The Goal of the Care Plan Problem was for the resident to display appropriate behaviors 100% of the time. Staff interventions listed on the Care Plan to address the resident's inappropriate behaviors included if resident displays inappropriate behavior redirect, offer an appropriate behavior so resident can express thoughts, monitor for mood and behavior and encourage resident to express thoughts and				

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			feelings. CNA Certified Nursing Assistant (CNA) why Resident #16 resided on the secured behavior unit, the CNA replied, because the resident talks to himself/herself. Review of the Interdisciplinary Progress Notes 01/01/16-04/22/16 revealed the following behavior documentation: 1. 01/26/16 11:53 Care Plan Goal: Resident will display appropriate behaviors 100% of the time. Monthly Summary: Resident #16 did not display appropriate behavior 100% of the time. The resident will say sexually inappropriate things and attempt to grope women at times. The resident also has conversations with unforeseen other, such as his deceased father. Goals is not met. 2. 01/27/16 20:30 Category: Behavior Management, Nursing: The resident approached another resident and raised his arm above the other resident. Staff redirected the resident without incident. 3. 02/29/16 11:00 Care Plan Goal: Resident will display appropriate behavior 100% of the time. Monthly Summary: Resident does not display appropriate behaviors 100% of the time. Resident is usually pleasant and cooperative but can also become verbally and physically inappropriate with staff and other residents. Goal is not met. 4. 03/23/16 14:10 Care Plan Goal: Resident will display appropriate behavior 100% of the time. Monthly Summary: Resident does not display appropriate behaviors 100% of the time. The resident is usually pleasant and cooperative but can also be verbally and physically inappropriate with staff and other residents. The resident is becoming more reclusive, and is staying in room and talking with unforeseen other. Goal is not met. 5. 03/27/16 19:50 Category: Medication, Behavior Management: Upon entering the resident's room, the resident was found to be talking softly aloud. When the nurse asked who the				

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			resident was speaking to, the resident replied, "The Lord." An interview with the Social Service Director (SSD) on 04/21/16 at 3:15pm revealed Behavior Management Meetings are held on the secured behavior unit once a month. Although the facility 's policy states resident's progress with behaviors will be discusses weekly, the SSD said only problematic behaviors are discussed at the meetings and unless a resident was exhibiting behavior problems they would not be discussed. The SSD said he/she had only been assigned to the unit for four (4) months and only knew two (2) residents on the unit and was not aware of Resident #16's behaviors. The Medical Director acknowledged Resident #16's goals to exhibit appropriate behavior 100% of time was not realistic, that no one exhibits appropriate behavior 100% of the time. The Medical Director further stated facility staff did not do a good job of documenting behaviors to justify the need for this resident to remain on the secured behavior unit. S/S=D				

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39	c. Protection of resident funds. 1. The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility. 2. Management of personal funds. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(6) of this section.	(M) Met					
40	3. Deposit of funds. i. Funds in excess of $100. The facility management must deposit any resident's personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on residents funds to that account. (In pooled accounts, there must be a separate accounting for each residents share.) ii. Funds less than $100. The facility management must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.	(N) Not Met	Funds exceeding $100 were not placed in Individual interest bearing accounts. It should be noted that the funds were in a pooled interest bearing account and the agency was in the process of manually posting the correct interest dividends to individual accounts. This finding was self-identifed by State Home administration prior to the arrival of the survey team and corrective action was underway to resolve the issue. The surveyor validated the finding as well as the corrective action being taken. S/S=F	<insert CAP details here>			
41	4. Accounting and records. The facility management must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. i. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. ii. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	(M) Met					

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93	2. A comprehensive care plan must be: i. Developed within 7 calendar days after completion of the comprehensive assessment; ii. Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and iii. Periodically reviewed and revised by a team of qualified persons after each assessment.	(P) Provisional Met	Based observation, interview and record review it was determined the facility to failed to update care plans to address wound care for two (2) of 30 sampled Residents,(Residents #10 and #26). Resident #10 had a pressure sore to the right heel for three (3) months and Resident #26 had been identified with a pressure sore to the left heel 18 days. Neither of the resident's care plans had been updated to reflect needed interventions for treatment. 1. Review of the medical record for Resident #10 revealed admission to the facility was on 10/22/14. Diagnoses included Dementia, Hypertension, Atrial Fibrillation, and Anemia. The admission nursing assessment dated 10/22/14 indicated the resident had intact skin. The quarterly Minimum Data Set (MDS) assessment dated 1/28/16 indicated the resident was cognitively intact with some confusion. The resident did require assistance with activities of daily living and transfers to and from bed. The MDS assessment also indicated the resident had a Stage 2 pressure sore on the right heel. Review of the nursing care plan dated 8/13/15 revealed a problem identified with being at risk for an alteration in skin integrity related to incontinence. There was a notation in the nutrition care plan dated 1/29/16 that indicated the resident had a wound present on right upper heel. There were no interventions listed in the care plan to treat wounds or pressure sores. Interview with the MDS Nurse on 4/21/16 at 9:30 A.M. revealed the assessments and care plans are very behind and they are trying to get caught up from March. Interview with the LPN on 4/22/16 at 9:30 A.M. revealed the LPN's don't have anything to do with the care plans. The MDS nurses and RN's develop the care plans and make any necessary revisions. Interview with the Assistant Director of Nursing (ADON) on 4/22/16 at 10:00	<insert CAP details here>			

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			A.M. confirmed the care plan for Resident #10 was not revised to include any interventions for the care or treatment of pressure sores. The ADON indicated that the MDS nurse does develop the care plan but any of the Staff RN's can go in to the computer and update or revise the care plan as changes occur. Review of the facility policy titled "Interdisciplinary Care Plan" dated 4/21/14 revealed the following: The Interdisciplinary Team is responsible for implementing and overseeing the updating of the written Care Plan. The team shall review all care plans no less than quarterly and as needed. The Case Manager will review the Care Plan monthly, initial, and then notify appropriate discipline(s) if changes may be needed. 2. Resident #26 was admitted to the facility on 7/13/12, and re-admitted on 3/4/16. Diagnoses included Morbid Obesity, Diabetes Mellitus, Chronic Pain, Obstructive Sleep Apnea, End-Stage Renal Disease, Personality Disorder, Hypertension, Anemia, Chronic Atrial Fibrillation, History of Traumatic Brain Injury and History of Deep Vein Thrombosis. The Significant Change Minimum Data Set (MDS) dated 2/2/16 recorded the resident was cognitively intact, required total staff assistance for transfers and bathing, and required extensive staff assistance for bed mobility, dressing, toilet use and hygiene. The MDS recorded the resident was at risk for pressure ulcers. The Pressure Ulcer Care Area Assessment (CAA) dated 2/9/16 indicated the resident was at high risk for pressure ulcers, had a rash in the groin and buttocks, had multiple incontinent stools and irritated skin despite preventive measures. The Braden Scale for Pressure Ulcer Risk dated 2/1/16 recorded the resident's score was 12, moderate risk for pressure ulcers. The assessment				

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			recorded the resident as "bedfast." The skin integrity care plan dated 10/22/15 directed staff: -Maintain sufficient fluid hydration. -Skin inspection at bath time, report any rashes, bruises or open areas to charge nurse. -Feet to be inspected nightly due to diagnosis of Diabetes Mellitus. -Report any symptoms of erythema and blanching. Palpate for warmth and tissue sponginess. Do not rub reddened areas or over bony prominences. -Pressure relief mattress on [resident's] bed. DO NOT over pad the mattress. -Roho cushion in [resident's] wheelchair. -Apply lotion to dry skin. -Keep bedding clean and wrinkle free. -Document condition of wound weekly in chart after dressing changes. -Apply dressing/treatment as ordered. -4/10/16 Turn and reposition with devices every 2 hours. -4/10/16 Position of comfort. Frequent observation on 4/22/16 from 10:20 A.M. - 11:00 A.M. revealed the resident asleep in his/her bed, with the head of the bed raised and the resident's bare feet pressed against the footboard in a "toes out" position with heels together, and with both outer ankles against the mattress. Kerlix gauze was visible on both ankles. No foam boots or pillows for offloading pressure on the feet were in place. Interview on 4/22/16 at 11:01 A.M. with the resident's assigned contract Certified Nursing Assistant (CNA) revealed he/she came to the unit for work at 8:00 A.M. The CNA stated he/she did not know if the resident was cognitively intact, did not know if the resident should be placed in the electric wheelchair or in the Broda chair, did not know if the resident had any current skin problems, and did not know if the resident could move him/herself in the bed without assistance from staff. The CNA stated he/she went according to the				

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			"Caregiver Cheat Sheet" to determine the care a resident required. The CNA verified the "Cheat Sheet" did not document skin problems, which chair to use, or if the resident was able to move independently in the bed. Interview on 4/22/16 at 11:15 A.M. with the Assistant Director of Nursing (ADON) on that unit revealed the ADON has been assigned on the unit for three (3) weeks. During that time, the resident did not want to get out of bed, and was basically bedfast. The ADON stated the care plan interventions should have been listed on the CNA Cheat Sheet. During observation of the resident at that time with the ADON, the ADON stated, "The resident should not have the feet pressed against the footboard." Documentation of Interdisciplinary Progress Notes (IPN) revealed the following: Late Entry for 3/30/16, recorded on 4/4/16 by the physician, "...There continues to be a 2 cm (centimeter) grade II (Stage II) decubitus overlying the lateral malleolus of the left ankle." IPN dated 4/10/16 recorded, "Stage 2 decubitus ulcer on left outer ankle. Area measures 1-1/2 cm in diameter. Small amount of light yellow exudate. Area cleansed with hibiclens, triple antibiotic applied and dressing applied. Placed on sick call...Message left with wound care. Soft blue boots on to decrease pressure and heels up on pillow. Right shin wound is nearly healed. Member [resident] repositioned Q2H [every 2 hours] and as [he/she] requests." The ADON stated on 4/22/16 at 12:20 P.M. that the resident had the left ankle wound on 4/4/16, as evidenced by the physician's note, but no treatment was initiated until 4/10/16, and the care plan was not updated; it was unknown when the wound was found. On 4/10/16, the note described interventions such as blue boots and a pillow under the heels, but the resident did not have them in place, and they			

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			were not listed as interventions on the care plan or on the CNA Cheat Sheet. The ADON also stated the care plan was not up to date with interventions and the care plan had discontinued interventions because the resident did not have a pressure reducing mattress on his/her bed, and no longer had a right leg wound. The ADON stated the unit RN, the ADON and the MDS nurse were responsible to keep the CNA Cheat Sheet updated, based on the care plan interventions. The ADON stated, "Obviously we have a lack of nursing and wound care documentation." The facility provided the policy titled, Interdisciplinary Care Plan dated 4/21/14, which directed, "6. The Interdisciplinary Team is responsible for implementing and overseeing the updating of the written care Plan. The team shall review all care plans no less than quarterly and as needed..." S/S=D				

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94	3. The services provided or arranged by the facility must: i. Meet professional standards of quality; and ii. Be provided by qualified persons in accordance with each resident's written plan of care.	(P) Provisional Met	Based on observation, interview, record review, and review of facility policy it was determined the facility failed to provide services that meet professional standards for one (1) of 30 sampled residents, Resident #16. Resident #16 had resided on the secured behavior unit for six (6) years. The goal of the resident's care plan was, "To exhibit appropriate behavior 100% of the time." Although staff interview indicated this was an unrealistic goal that no one could meet, review of documentation in the record revealed the resident remained on the secured behavior unit because the goal of exhibiting appropriate behavior 100% of the time was not met. The findings include: Review of the facility's policy, "Interdisciplinary Care Plan," dated 04/21/14 revealed the purpose of the policy is to provide resident's with consistent, coordinated, and comprehensive multidisciplinary care designed to help each resident reach and maintain his/her optimal level of functioning. Care Plans will include specific goals with measurable outcomes and specific time frames. Goals should be realistic and attainable. During an initial tour of the secured behavior unit on 04/19/16 at 9:30am, the surveyor asked a CNA (certified nursing assistant) why Resident #16 was on the secure behavior unit. The CNA replied, because the resident talks to himself/herself. Resident #16 was observed on 04/21/16 at 10:15am in the dayroom/dining room area of the secured behavior unit with a songbook in hand singing religious songs with other residents and a volunteer. A further observation on 04/22/16 at 10:10am revealed the resident was sitting in the dayroom/dining room of the secured behavior unit watching a Western movie on TV. The resident smiled when he/she was spoken to and replied to with a smile to any question	<insert CAP details here>			

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			asked, "Everything is just fine." Review of Resident #16's clinical record revealed the resident was admitted to the facility and to the secured behavior unit of the facility on 01/06/10. The resident's diagnosis included Korsakoff's Dementia, History of Alcohol Abuse, Hypertension, Depression and Persistent Delusions. Review of the quarterly MDS Assessment dated 04/06/16 revealed the resident was assessed to have moderately impaired cognitive status, had exhibited no behaviors during the assessment period, required no assistance/supervision with bed mobility, transfers or ambulation, required supervision only with meals, required one (1) person physical assistance with dressing and toilet use, and required two (2) person physical assistance with bathing and hygiene. Resident #16's Care Plan with revision date of 02/05/16 stated a Care Plan Problem included the resident had memory deficits due to Korsakoff's dementia and the resident benefits from the controlled structured environment of the secured behavior care unit. The resident can present with inappropriate behaviors at times, such as inappropriate touching. The Goal of the Care Plan Problem was for the resident to display appropriate behaviors 100% of the time. Staff interventions listed on the Care Plan to address the resident's inappropriate behaviors included if resident displays inappropriate behavior redirect, offer an appropriate behavior so resident can express thoughts, monitor for mood and behavior and encourage resident to express thoughts and feelings. Review of the interdisciplinary Progress Notes 01/01/16-04/22/16 revealed the following behaviors documentation for the resident: 1. 01/26/16 11:53 Care Plan Goal: Resident will display appropriate behaviors 100% of the time. Monthly				

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			Summary: Resident #16 did not display appropriate behavior 100% of the time. The resident will say sexually inappropriate things and attempt to grope women at times. The resident also has conversations with unforeseen other, such as his deceased father. Goals is not met. 2. 01/27/16 20:30 Category: Behavior Management, Nursing: The resident approached another resident and raised his arm above the other resident. Staff redirected the resident without incident. 3. 02/29/16 11:00 Care Plan Goal: Resident will display appropriate behavior 100% of the time. Monthly Summary: Resident does not display appropriate behaviors 100% of the time. Resident is usually pleasant and cooperative but can also become verbally and physically inappropriate with staff and other residents. Goal is not met. 4. 03/23/16 14:10 Care Plan Goal: Resident will display appropriate behavior 100% of the time. Monthly Summary: Resident does not display appropriate behaviors 100% of the time. The resident is usually pleasant and cooperative but can also be verbally and physically inappropriate with staff and other residents. The resident is becoming more reclusive, and is staying in room and talking with unforeseen others. Goal is not met. 5. 03/27/16 19:50 Category: Medication, Behavior Management: Upon entering the resident's room, the resident was found to be talking softly aloud. When the nurse asked who the resident was speaking to, the resident replied, "The Lord." An interview with the Social Service Director (SSD) on 04/21/16 at 3:15pm revealed Behavior Management Meeting are held on the secured behavior unit once a month. Although the facility 's policy states residents progress with behaviors will be discusses weekly, the SSD said only problematic behaviors are discussed at the meetings and unless a resident			

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			was exhibiting behavior problems the residents would not be discussed. The SSD said he/she had been assigned to the unit for four (4) months and only knew two (2) residents on the unit and was not aware of Resident #16's behaviors. The Medical Director acknowledged Resident #16's goal to exhibit appropriate behavior 100% of time was not realistic, that no one exhibits appropriate behavior 100% of the time. The Medical Director further stated facility staff did not do a good job of documenting behaviors to justify the need for Resident #16 to remain on the secured behavior unit. S/S=D				
95	f. Discharge summary. Prior to discharging a resident, the facility management must prepare a discharge summary that includes— (1) A recapitulation of the resident's stay; (2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	(M) Met					

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102	d. Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	(N) Not Met	Based on observation, interview, record review, and facility policy review, the facility failed to maintain an effective wound management program. This failure resulted in three (3) of 30 sampled residents on three (3) of 12 skilled nursing units developing pressure sores. (Residents #10, #19, #26) The findings include: 1. Review of the medical record for Resident #10 revealed admission to the facility was on 10/22/14. Diagnoses included Dementia, Hypertension, Atrial Fibrillation, and Anemia. The admission nursing assessment dated 10/22/14 indicated the resident had intact skin. The Minimum Data Set (MDS) assessment dated 1/28/16 indicated the resident was cognitively intact with some confusion. The resident did require assistance with activities of daily living and transfers to and from bed. The MDS assessment also indicated the resident had a stage 2 pressure sore on the right heel. There was a physician order dated 1/4/16 to have the wound nurse evaluate the right heel wound. Review of the nursing care plan dated 8/13/15 revealed a problem identified with being at risk for an alteration in skin integrity related to incontinence. There was no problem identified with being at risk for pressure sores. There was a notation in the nutrition care plan dated 1/29/16 that indicated the resident had a wound present on right upper heel. There were no interventions listed in the care plan to treat wounds or pressure sores. The Caregiver Cheat Sheet indicated the resident required a Sara lift, with two (2) people, to transfer to the wheelchair, and needed toileting after each meal. Review of the Certified Nursing Assistant (CNA) documentation for April 9-22, 2016 revealed 25 out of 42 shifts did not have any documentation of care being provided. An observation of wound care and	<insert CAP details here>			

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			dressing change for Resident #10 was conducted on 4/20/16 at 8:30 A.M. The Wound Care Nurse (WCN) gathered supplies and placed them on the bedside table without using a barrier or cleaning the table. The resident's brief was unfastened and assisted to turn over. The brief was soiled with stool and was pushed to the side to reveal a dime size red pressure sore over the resident's coccyx. The WCN did not clean the resident of stool or remove the soiled brief. Instead, he/she stated a caregiver would be notified of the need after the dressing was changed. The old dressing was removed and the wound was measured and then cleaned with wound cleanser and gauze. The WCN removed the soiled gloves and donned new gloves without washing his/her hands or performing hand hygiene. The WCN then removed the gloves, left the room, and returned with additional supplies. New gloves were donned without any hand washing or hand hygiene. After the new dressing was applied, the WCN fastened the soiled brief on the resident and then left the room. Interview with Resident #10 on 4/20/16 at 9:00 A.M. revealed he/she cannot get out of bed without assistance from staff. The resident stated that he/she had been waiting all morning for someone to assist with getting dressed and getting up in the chair. An unidentified resident in the room stated no one had been around to help all weekend. Interview with the WCN on 4/20/16 at 9:20 A.M. revealed there was a message left for Resident #10 to be seen because of a new pressure sore on the coccyx. The WCN indicated the resident had a pressure sore on the right heel which had healed but the sore on the coccyx developed over the weekend. 2. Review of the medical record for Resident #19 revealed admission to the facility was on 2/17/16. Diagnoses included Atrial Fibrillation, Hypertension, Congestive Heart				

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			Failure, and Edema. The admission nursing assessment dated 2/17/16 revealed the resident's skin was intact. The admission MDS assessment dated 2/23/16 indicated the resident had moderate cognitive impairment. The resident ambulates with a walker and has some extremity impaired on the left. He/she requires assistance to transfer and re-position in bed. Review of the care plan dated 3/4/16 revealed a problem identified with newly acquired wounds on bilateral heels. The Caregiver Cheat Sheet indicated the CNA was to assist the resident with transfers to the wheelchair, and toilet every two (2) hours. Review of the CNA care documentation for April 9-22, 2016 revealed 12 out of 42 shifts did not have any documentation of care being provided. An observation of wound care and dressing change for Resident #19 was conducted on 4/20/16 at 9:30 A.M. The WCN gathered supplies from the cart and placed them on the resident's dresser without using a barrier. The WCN removed scissors and gloves from his/her pocket and placed them on the bedside table without a barrier. After donning gloves, the nurse used the scissors to cut off the old dressing from the resident's left foot without cleaning the scissors. Five (5) wounds were identified on the left foot. The WCN stated he/she was aware of two (2) wounds but there were three (3) new ones that had not been previously assessed. The wounds on the left foot were measured. Wound cleanser was sprayed on all the wounds and wiped with gauze. The WCN removed the soiled gloves, opened the clean supplies, and then donned new gloves without performing hand washing or hand hygiene. The WCN then left the room and returned with more dressing supplies. The blue pad, which had been placed under the resident's foot, fell on the floor leaving the resident's open wounds resting on the bed spread. The WCN placed a new blue pad under the				

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			resident's foot and then removed the soiled gloves. New gloves were donned without performing hand washing or hand hygiene. All the wounds on the left foot were dressed and wrapped in gauze. Old gloves were removed and new gloves donned without any hand washing or hand hygiene. The WCN proceeded to cut off the old dressing from the right foot with the previously used scissors which had not been cleaned. Wound cleanser was sprayed on the right heel and wiped with gauze. The wound was re-dressed and the WCN left the room. During the wound care observation, the resident asked multiple times why he/she had these foot wounds since never having problems with his/her feet before. The WCN told the resident that the wounds were probably from his shoes. The resident indicated that he/she had not been wearing any shoes because the weekend was spent in bed. An interview was conducted with the WCN on 4/21/16 at 2:00 P.M. The nurse revealed that he/she was a Licensed Practical Nurse (LPN) and was not certified in wound care. The LPN stated "I have just picked up information from the RN's who used to handle the wound care. We no longer have a wound care team. The floor nurses will leave a message in my office if something needs seen. I will assess and measure the wounds and write my recommendations. The physician will then sign the orders. I don't make rounds with the physician and I don't know how often the physician will see wounds. I make a report at the end of the month for all the wounds and I submit it to the Infection Control Nurse but I don't know what happens to it after that. I don't attend any of the Quality Assurance meetings." An interview was conducted with the Unit Physician on 4/21/16 at 2:40 P.M. When asked about the new wounds on Resident #19, the physician indicated no knowledge of any new wounds. The			

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			communication book was reviewed and no notes had been written regarding new wounds on Resident #19. Review of the medical record revealed the physician had signed the new treatment orders for Resident #19 dated 4/20/16. The physician stated "I rely on the nurses to inform me of any new changes and I also get information from this communication book. I rely on the WCN's judgment to see the wounds and make treatment recommendations." The physician indicated that he/she was not aware that the WCN had no formal training for assessing wounds. "We used to have a wound care team and several nurses but I guess we don't have that anymore. I could refer to the wound care clinic but I don't think they come here anymore either. We would have to send them out. I do see the wounds if the nurse wants me too." The physician then left and went to see Resident #19's wounds. Upon return, he/she confirmed the presence of three (3) or four (4) new wounds but indicated one (1) of those looked like an abrasion with a scab and not a pressure sore. An interview was conducted with the Interim Director of Nursing (DON) on 4/21/16 at 3:30 P.M. The DON confirmed the facility does not currently have a wound care program. Any training the WCN has was from old staff and is out of date. The Wound Care Clinic no longer comes into the facility and residents have to be sent out for special treatments. The DON indicated that budget cuts have hurt the facility across the board. An interview with a Staff RN on 4/21/16 at 9:30 A.M. revealed the facility has a terrible staffing problem. Weekends are the worst, and there might only be one (1) Certified Nursing Assistant (CNA) for an entire unit. The nurses can't get their own work done because they are trying to provide direct care to the residents. The Staff RN indicated that residents were not getting up on the weekends because				

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			they were afraid there would be no one to help them back to bed. The nurse stated "I am pretty sure that lack of staffing on weekends is why we have some new wounds." Review of the facility policy titled "Skin Care, Wound Prevention and Wound Management" dated 2/27/13 revealed nursing staff will regularly assess skin condition of all members and will provide appropriate nursing interventions, based upon those assessments. All licensed personnel will assess wound site during dressing changes. Treatment will be based upon assessment according to physician's orders, recommendations from the Wound and Skin Nurses or Wound and Skin Routine Standing Orders. The standing order sheet stated to follow the wound and skin routine standing orders for treatment recommendations first. If more serious treatment is required, notify the physician so he can write a referral for the Wound Care Team to evaluate. Previous staff interviews confirmed the facility no longer has a Wound Care Team for referral. Review of the facility policy for Universal Precautions revealed gloves should be changed after contact with each member and hands washed immediately after glove removal. The use of hand sanitizer is acceptable if hands are not visibly soiled. Multiple glove changes were observed during wound care that did not include any hand washing or hand sanitizer. 3) Resident #26 was admitted to the facility on 7/13/12, and re-admitted on 3/4/16. Diagnoses included Morbid Obesity, Diabetes Mellitus, Chronic Pain, Obstructive Sleep Apnea, End-Stage Renal Disease, Personality Disorder, Hypertension, Anemia, Chronic Atrial Fibrillation, History of Traumatic Brain Injury and History of Deep Vein Thrombosis. The Significant Change Minimum Data Set (MDS) dated 2/2/16 recorded the resident was cognitively intact, required total staff assistance for				

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			transfers and bathing, and required extensive staff assistance for bed mobility, dressing, toilet use and hygiene. The MDS recorded the resident was at risk for pressure ulcers. The Pressure Ulcer Care Area Assessment (CAA) dated 2/9/16 indicated the resident was at high risk for pressure ulcers, had a rash in the groin and buttocks, had multiple incontinent stools and irritated skin despite preventive measures. The Braden Scale for Pressure Ulcer Risk dated 2/1/16 recorded the resident's score was 12, moderate risk for pressure ulcers. The assessment recorded the resident as "bedfast." The skin integrity care plan dated 10/22/15 directed staff: -Maintain sufficient fluid hydration. -Skin inspection at bath time, report any rashes, bruises or open areas to charge nurse. -Feet to be inspected nightly due to diagnosis of Diabetes Mellitus. -Report any symptoms of erythema and blanching. Palpate for warmth and tissue sponginess. Do not rub reddened areas or over bony prominences. -Pressure relief mattress on [resident's] bed. DO NOT over pad the mattress. -Roho cushion in [resident's] wheelchair. -Apply lotion to dry skin. -Keep bedding clean and wrinkle free. -Document condition of wound weekly in chart after dressing changes. -Apply dressing/treatment as ordered. -4/10/16 Turn and reposition with devices every 2 hours. -4/10/16 Position of comfort. Review of the Weekly Nursing Wound Assessment dated 4/14/16 revealed the resident acquired a new Stage II pressure ulcer on the left outer ankle. Date of the new pressure ulcer was not recorded on the assessment. The Weekly Nursing Wound Assessments and measurements were only completed for 4/14/16 and 4/21/16.			

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			Frequent observation on 4/22/16 from 10:20 A.M. - 11:00 A.M. revealed the resident asleep in his/her bed, with the head of the bed raised and the resident's bare feet pressed against the footboard in a "toes out" position with heels together, and with both outer ankles against the mattress. Kerlix gauze was visible on both ankles. No foam boots or pillows for offloading pressure on the feet were in place. Interview on 4/22/16 at 11:01 A.M. with the resident's assigned contract Certified Nursing Assistant (CNA) revealed he/she came to the unit for work at 8:00 A.M., and checked the resident for incontinence. The CNA stated no incontinence checks or repositioning were done for the resident since that time (3 hours). The CNA stated he/she did not know if the resident was cognitively intact, did not know if the resident should be placed in the electric wheelchair or in the Broda chair, did not know if the resident had any current skin problems, and did not know if the resident could move him/herself in the bed without assistance from staff. The CNA stated he/she went according to the "Caregiver Cheat Sheet" to determine the care a resident required. The CNA verified the "Cheat Sheet" did not document skin problems, which chair to use, or if the resident was able to move independently in the bed. The CNA stated he/she was going to give the resident a bed bath and get the resident up. Interview on 4/22/16 at 11:15 A.M. with the Assistant Director of Nursing (ADON) on that unit revealed the ADON has been assigned on the unit for three (3) weeks. During that time, the resident did not want to get out of bed, and was basically bedfast. The ADON thought the resident's left ankle wound was found during routine daily care, but was not able to find any documentation of this. The ADON stated the care plan interventions should have been listed on the CNA Cheat Sheet. During observation of				

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			the resident at that time with the ADON, the ADON stated, "The resident should not have the feet pressed against the footboard." Observation of the resident on 4/22/16 at 11:36 A.M. revealed the assigned contract CNA and the contract Registered Nurse (RN) repositioned the resident by using the three (3) pads under the resident's buttocks. The staff failed to lift the resident, and dragged his/her buttocks over the mattress to move the resident up in the bed. Upon request, the contract RN assessed the resident as having a non-blanchable red area on the ball of the resident's right foot. Upon request, the ADON assessed the resident as having a Stage I pressure ulcer on the ball of the right foot, a second Stage I pressure ulcer on the left great toe, a third Stage I pressure ulcer on the right 2nd toe, and a previously unidentified scab on the right 3rd toe. The ADON described the skin as feeling "boggy". The ADON acknowledged the resident slid down in the bed with his/her feet pressed against the footboard for over three (3) hours, and verified the scabbed area was not reported. The ADON stated the three (3) new pressure areas were new pressure wounds, probably from the resident's feet pressing against the footboard. The ADON verified the Stage I pressure areas were not listed on the 4/21/16 wound report. Later interview at 12:20 P.M. with the ADON revealed there was no documentation on the origination date of the left ankle wound. The ADON stated some wounds were treated by the floor nurses, and some wounds were referred to the wound nurse. The wound nurse was unavailable for interview. Documentation of Interdisciplinary Progress Notes (IPN) revealed the following: Late Entry for 3/30/16, recorded on 4/4/16 by the physician, "...There continues to be a 2 cm (centimeter) grade II (Stage II)				

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			decubitus overlying the lateral malleolus of the left ankle." IPN dated 4/10/16 recorded, "Stage 2 decubitus ulcer on left outer ankle. Area measures 1-1/2 cm in diameter. Small amount of light yellow exudate. Area cleansed with hibiclens, triple antibiotic applied and dressing applied. Placed on sick call...Message left with wound care. Soft blue boots on to decrease pressure and heels up on pillow. Right shin wound is nearly healed. Member [resident] repositioned Q2H [every 2 hours] and as [he/she] requests." The ADON stated on 4/22/16 at 12:20 P.M. that the resident had the left ankle wound on 4/4/16, as evidenced by the physician's note, but no treatment was initiated until 4/10/16. On 4/10/16, the note described interventions such as blue boots and a pillow under the heels, but the resident did not have them in place, and they were not listed as interventions on the care plan or on the CNA Cheat Sheet. The treatment initiated on 4/10/16 was not documented on the Treatment Administration Record (TAR) for April; the ADON stated he/she was not sure the resident received the treatment until the order was written for treatment by the wound nurse on 4/14/16, but it was unknown when the wound was first noticed by staff, and the scabbed area had no documentation at all in the record. The ADON also stated the care plan was not up to date with interventions and the care plan had discontinued interventions because the resident did not have a pressure reducing mattress on his/her bed, and no longer had a right leg wound. The ADON stated, "Obviously we have a lack of nursing and wound care documentation." The facility provided the policy titled Skin Care, Wound Prevention and Wound Management dated 2/27/13, which directed, "...Members at Risk and/or Pressure Ulcers/Wounds...A. Caregivers will do a visual/head to toe skin assessment with weekly bath and			

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			PRN [as needed]. Caregivers will report any unusual findings to charge nurse/supervisor...Nursing staff will maintain the present state of skin integrity in [facility] members through admission and continued assessments and will provide appropriate nursing interventions based on continuous assessment data...Skin Care for Members Immobilized or a Risk for Pressure Ulcer Development. 1. The member shall be turned every 2 hours, unless contraindicated. 2. Heel/elbow protectors shall be used as appropriate (order not required)...4. Positioning devices such as foam or pillows may be placed between bony prominences to prevent direct contact...6. Staff may use one extra sheet or incontinence pad as needed. 7. Use a sheet to move m ember. Lift; do not drag" The facility had multiple failures that resulted in the breakdown of their system for wound care management. 1. Failure to update and implement effective policies and procedures. 2. Failure to maintain trained wound care nurses. 3. Failure to accurately assess and document resident wounds. 4. Failure to review and revise resident care plans. 5. Failure to implement appropriate interventions to prevent pressure sores. S/S=F				

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103	e. Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that: 1. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and 2. A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	(P) Provisional Met	Based on observation, interview and record review it was determined the facility failed to provide treatment and services in an attempt to restore normal bladder function for one (1) of 30 sampled residents, (Resident #15). Resident #15 was identified as continent of urine, the facility could provide no evidence that services had been provided by the facility at any time in an attempt to restore the resident's bladder function. The findings include: Resident # 15 was observed on 04/19/16 at 2:50pm sitting in a wheelchair in the dayroom/dining room on the behavior unit. The resident was drinking fluids from a cup and appeared to be actively listening to a crossword activity conducted by the unit activity director. Review of Resident #15's clinical record revealed the resident was admitted to the facility on 10/26/04. The resident's diagnoses included Bipolar Disorder, Schizophrenia, Chronic Hepatitis C, Hypertension and Chronic Obstructive Pulmonary Disease. Review of the quarterly Minimum Data Set Assessment (MDS) dated 02/27/16 revealed the resident's cognitive status was intact with no mood or behavior symptoms exhibited during the assessment period. According to the assessment the resident required supervision with meals, minimal assistance with bed mobility and required extensive assistance with transfers, mobility, dressing, personal hygiene, bathing and toilet use. The assessment indicated the resident was always incontinent of bowel and bladder, and since urinary incontinence was first noted a trial of a toileting program (e.g., scheduled toileting, prompted voiding or bladder training) had not been attempted to restore the resident's bladder function. The resident's care plan with revision date of 03/25/16 listed problems of Self-Care Deficit related to deconditioning and impaired cognition	<insert CAP details here>			

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			and Risk for Alteration in Skin Integrity. Staff interventions included: Resident is incontinent of bowel and bladder. Wears briefs at all times. Staff to change and cleanse area every two (2) hour and as needed. Report to licensed nurse if any excoriation is noted. A Certified Nursing Assistant (CNA) stated on 04/22/16 at 9:00am that only one (1) of the 23 residents residing on the secured behavior unit had a scheduled toileting program in place. He/she said the un-sampled resident's family had devised the toileting schedule for the resident, and staff follow that schedule to keep the resident continent. An interview with the MDS nurse on 04/21/16 at 2:30pm revealed he/she was aware at one point Resident #15 was continent of bladder, but could not say when the incontinence first occurred. The MDS nurse said the facility does not have a formal bowel and bladder toileting program, it was something the facility needed to work on. The Unit Manager acknowledged on 04/21/16 at 2:35pm a toileting program needed to be attempted for Resident #15. The Director of Nursing (DON) stated on 04/21/16 at 3:30pm the facility had no policy and procedure in place to address restoration of resident's bowel and bladder function. S/S=D				

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104	3. A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.	(P) Provisional Met	Based on observation, interview and record review it was determined the facility failed to provide treatment and services in an attempt to restore normal bowel function for one (1) of 30 sampled residents, Resident #15. Resident #15 had multiple documented behaviors of smearing BM. Staff stated in the past the resident had been continent of bowel and could not say when the resident had become incontinent of bowel. The facility had not implemented a toileting program in an attempt to restore the resident's bowel function as staff said the facility did not have a formal bowel program. The findings include: Resident # 15 was observed on 04/19/16 at 2:50pm sitting in a wheelchair in the dayroom/dining room on the behavior unit. The resident was drinking fluids from a cup and appeared to be actively listening to a crossword activity conducted by the unit activity director. Review of Resident #15's clinical record revealed the resident was admitted to the facility on 10/26/04. The resident's diagnoses included Bipolar Disorder, Schizophrenia, Chronic Hepatitis C, Hypertension and Chronic Obstructive Pulmonary Disease. Review of the quarterly Minimum Data Set Assessment (MDS) dated 02/27/16 revealed the resident's cognitive status was intact with no mood or behavior symptoms exhibited during the assessment period. According to the assessment the resident required supervision with meals, minimal assistance with bed mobility and required extensive assistance with transfers, mobility, dressing, personal hygiene, bathing and toilet use. The assessment indicated the resident was always incontinent of bowel and a toileting program was not being used to manage the resident's bowel incontinence. The resident's care plan with revision date of 03/25/16 with problems listed	<insert CAP details here>			

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			of Self-Care Deficit related to deconditioning and impaired cognition, and Risk for Alteration in Skin Integrity included staff interventions: Resident is incontinent of bowel and bladder. Wears briefs at all times. Staff to change and cleanse area every two (2) hour and as needed. Report to licensed nurse if any excoriation is noted. Behavioral Symptoms of socially inappropriate behavior include socially inappropriate /disruptive behaviors to include screaming, sexual behavior and smearing feces. Review of the Interdisciplinary Progress Notes revealed the following: 01/08/16 13:55, Category, Physician Sick Call: Resident was moved to the Courtyard (Behavior Unit) because of confusional state and preoccupation with smearing feces. 01/09/16 19:42, Category: Behavior Management: Resident had placed BM on a table in the dining room, with BM on his/her hands and floor. 01/10/16 13:55, Category: Behavior Management: Resident placed two (2) piles of BM on another resident's tray in the dining room. The other resident had left the dining room 01/11/16 16:21, Category: Behavior Management, Social Work Progress Note: Staff report all through the week-end resident smeared feces in and on various objects. 01/19/16 12:50, Category: Behavior Management: Resident smeared BM on the table in the dining room and floor. 01/23/16 18:54, Category: Behavior Management, Nursing: Just before supper resident was in the dining room with feces on hands and on the floor. 01/25/16 13:48, Category: Behavior Management: Resident was in the dining room and began to dig himself/herself out. The resident placed BM in the dining room floor. 01/27/16 12:26, Category: Behavioral Symptoms, Communication: Behavior Management, Social Work Progress Note: Resident continues to smear feces everywhere while in the dining			

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			area. Psychologists have been made aware of this behavior and have provided labels to the behavior, but no interventions to address the behavior. 01/28/16 13:34, Category: Behavior Management: At approximately 12 noon resident was in the dining room and began dig BM out of his brief and wipe it on the table. 01/29/16 13:49, Category: Behavior Management: The resident is belligerent with staff and began to dig himself out in the hallway. Staff saw BM all over resident's hand. 01/29/16 09:17 Care Plan Problem Behavioral Symptoms: Socially Inappropriate Behaviors. Care Plan goal: Resident will not smear feces throughout facility. Monthly Summary: This goal has not been met. Will smear BM in room and dining room. There is no redirecting the resident for this behavior. 02/09/16 07:05 Category: Behavior Management: At 0600am staff discovered resident in bed awake playing with feces. 02/21/16 21:28 Category: Behavior Management: After HS care and resident in bed, staff went back into room and found resident had smeared feces on himself and bed. 02/29/16 10:07, Category: Physician Sick Call: The resident has a pattern of digging in his rectum and smearing feces along the wall, his bed and sometimes other public areas. The resident was seen today for a rash on his buttocks and posterior thighs. He/she is frequently soiled and appears that the skin has become irritated because of sitting in stool. Miconazole 2% powder to be applied twice daily. A trial of frequent toileting maybe necessary to try to keep resident dry. (This was not attempted by staff). 02/29/16 12:27, Care Plan Problem Behavioral Symptoms: Socially Inappropriate Behaviors. Care Plan goal: Resident will not smear feces throughout facility. Monthly summary: Goal is not met. Continues				

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
			to smear feces and there is no redirecting resident for behavior. 03/03/16 13:29, Category: Nursing: Resident was found this am with BM spread over headboard of bed. 03/10/16 22:55, Category: Behavior Management: Resident had BM smeared on bed. 03/23/16 11:40 Category: Behavior Management Unit Meeting: Behavior management review meeting held due to ongoing behaviors of smearing feces, verbal frustration and repetitive language. The trend is this behaviors occur when in bed. 03/24/16 14:48, Care Plan Problem, Behavioral Symptoms: Socially Inappropriate Behaviors. Care Plan Goal: Resident will not smear feces throughout facility. Usually smears BM in bedroom, had not smeared BM in the dining room lately. 04/12/16 11:36, Category: Behavior Management, Nursing: Late entry for 04/11/16 3-11, Resident was found with BM on his right hand and on top of covers after he/she had attempted to manually remove BM from himself/herself. A Certified Nursing Assistant (CNA) stated on 04/22/16 at 9:00am that Resident #15 was not toileted by staff, that the resident was changed when soiled. The CNA said only one (1) of the twenty-three (23) residents residing on the secured behavior unit had a scheduled toileting program in place. He/she said the un-sampled resident's family had devised the toileting schedule for the resident, and staff follows the schedule to keep the un-sampled resident continent. An interview with the MDS nurse on 04/21/16 at 2:30pm revealed he/she was aware that at one point Resident #15 was continent of bowel and bladder, but could not say when the incontinence first occurred. The MDS nurse said the facility does not have a formal bowel and bladder toileting program, and thus bowel and bladder training had never been attempted for Resident #15. He/she said it was				

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108	I. Accidents. The facility management must ensure that: 1. The resident environment remains as free of accident hazards as is possible; and 2. Each resident receives adequate supervision and assistance devices to prevent accidents.	(P) Provisional Met	Based on observation, interview and record review the facility failed to provide adequate supervision and failed to revise the care plan with appropriate safety interventions for one (1) resident from a sampled 30 residents. (Resident#14) Resident #14 was identified with a history of unsafe smoking which resulted in an unintentional fire and a burn injury. Findings included: Resident (#14) was admitted to the facility on 9/02/2004 with the diagnoses of right sided hemiparesis, traumatic brain injury and organic brain syndrome with aggressive behaviors. The quarterly Minimum Data Set assessment dated 3/03/2016 documented the resident had intact cognition. Review of the clinical record revealed on 4/25/15 at 4:00 P.M. the resident was smoking when a cigarette or cigarette remains fell into a bag that was attached to the resident's wheelchair causing the bag to ignite with fire. A staff member was present and removed the bag from the wheelchair and extinguished the fire. The assessment indicated staff were to remove the hanging items from the resident's chair to prevent further fires. The facility staff assessed the resident's safety with smoking on 7/18/15 and indicated the resident was not safe to smoke unless a protective apron was worn and staff supervised the resident. Further review revealed a quarterly smoking assessment dated 3/10/16 that documented the resident was not alert and oriented and had a history of poor judgment. The resident was given a pipe and tobacco and was not to have cigarettes. Staff checked the resident to ensure no cigarettes were picked up by the resident. Staff determined the resident was able to smoke without supervision and continue to smoke independently. On 4/19/16 staff assessed the resident's safety with smoking again and documented the resident was alert, oriented and had a history of poor	<insert CAP details here>			

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117	c. The director of nursing services must designate a registered nurse as a supervising nurse for each tour of duty. 2. Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes. 1. Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes.	(M) Met					
118	d. The facility management must provide nursing services to ensure that there is a minimum direct care nurse staffing per patient per 24 hours, 7 days per week of no less than 2.5 hours.	(N) Not Met	As reflected in the State of Michigan Auditor General's report, during the period of April 2015-June 2015, the agency failed to meet staffing requirements 81% of the time. On one of the 28 days reviewed during this survey, staffing was at 2.4 hours. It should be noted that dates reviewed by the survey team were within the past 90 days of the survey date and included two holiday periods. S/S=F	<insert CAP details here>			

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
119	e. Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part.	(N) Not Met	Based on observations, interviews and record review it was determined that although the facility's minimum direct care nurse staffing per patient per 24 hours was documented as 2.7, numerous interviews from residents, resident family members and staff revealed resident care needs were not always met. This survey findings support these interviews. The findings include: 1. The facility had no formal toileting program or policies and procedures in place to address bowel and bladder incontinence. 2. Three (3) residents without pressure sores developed facility acquired pressure sores, Resident's #10, #19 and #26. 3. Review of scheduled bath list dated 11/11/15, and interviews with staff revealed to ensure residents received two (2) showers per week, showers are given to residents on the 11pm to 7am shift due to staffing issues. 4. During a group interview on 04/19/16 at 1:30pm with 41 residents present, interviews with residents, staff and family members indicated on week-ends there are at times only one (1) CNA (certified nursing assistant) per unit. 5. A resident group interview on 04/19/16 at 1:30pm, resident interviews and family interviews revealed there was no consistency with staff assignments, thus staff do not always know the care needs of residents. 6. During a group interview with residents on 04/19/16 at 1:30pm, and interviews with residents and family members revealed at times food is served cold due to lack of direct care staff to pass out food trays timely. 7. During a group interview with residents on 04/19/16 at 1:300pm, the residents stated at times call light response can be up to 25 to 45 minutes. 8. Residents were not always provided with supervision with	<insert CAP details here>			

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			smoking, Resident #14; and facility failed to provide supervision and treatment for a resident with Chronic Alcoholism, Resident #1. 9. There were numerous cigarette butts on facility grounds and a half empty Rum bottle was found in the bushes in front of the facility. 10. Observation of lack of staff response to fire drill conducted on 04/20/16. 11. Review of an abuse allegation dated 02/23/26 revealed the findings for the investigation included, "Acknowledgement, short staffing may be root cause for untimely responses to member's need." S/S=F				
120	§ 51.140 Dietary Services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. a. Staffing. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis. 1. If a qualified dietitian is not employed full-time, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian. 2. A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association.	(M) Met					
121	b. Sufficient staff. The facility management must employ sufficient support personnel competent to carry out the functions of the dietary service.	(M) Met					

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134	§ 51.160 Specialized rehabilitative services. a. Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must: 1. Provide the required services; or 2. Obtain the required services from an outside resource, in accordance with § 51.210(h) of this part, from a provider of specialized rehabilitative services.	(P) Provisional Met	Based on review of facility policy, clinical record reviews, interviews, and observation, the facility failed to ensure psychosocial services were provided for one (1) of 30 residents (Resident #1) who exhibited symptoms of Chronic Alcoholism while residing at the facility. The findings were: Review of the facility's policy entitled "Substance Abuse by a Member," with an effective date of 1231/15 noted the following: Directions for staff with members who have substance abuse issues. Guidelines A.3. "It is expected that any member who has a diagnosis of substance abuse/dependence and has not been in recovery for 12 consecutive months or more will be involved in some aspect(s) of a continuing care program for recovery." Record review of Resident #1's clinical record revealed the resident was admitted into the facility on 6/15/15 with diagnoses including Chronic Alcohol Dependence with Short-term Sobriety, and Anxious Depression. According to the resident's Recapitulation Orders for April 2016, Resident #1 was administered Lorazepam 1 milligram (mg) every six (6) hours for anxiety. Resident #1's Quarterly Minimum Data Set (MDS) assessment dated 3/21/16 assessed the resident as scoring 15/15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact; and the resident's mood score was 6, indicating moderate depression. Review of Resident #1's Interdisciplinary Progress Notes revealed the following: 11/6/15 – In resident's room, staff smelled a strong smell of alcohol; and resident was sound asleep and difficult to wake. A 750 milliliter (ml) of Canada House 80 proof whiskey was found near resident ("almost half of it was gone). 11/9/15 – Social worker to speak with member and work with him to obtain resources to assist in substance	<insert CAP details here>			

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			abuse. 3/11/16 – Charge nurse found a bottle of alcohol in member's room which is promptly removed. 3/19/16 – Resident #1 had "emesis on 1st shift. Resting comfortably in bed. It should be noted member was very inebriated last night...slurring words, difficult to wake, and over all very lethargic. He also had a very strong smell of alcohol emanating from him. Will continue to monitor." 3/30/16 – Aide reported Resident #1 in bed yelling and cursing at staff. The Resident smelled of alcohol, eyes were red and glassy, speech slurred and motor skills clumsy. In bed asleep at this time. 750 ml bottle of vodka found in bag on wheelchair, 4/5 of bottle had been consumed. 4/7/16 – Resident #1 "over the past 90 days has demonstrated episodes of drinking and drunken behaviors placing himself and staff at risk." The Resident "was loud and non-compliant with [his/her] care while drunk at times passed out outside needing to be brought in." Interview on 4/20/16 at 12:15 p.m. with Resident #1 revealed the Resident ate his/her lunch meal in his/her room. Resident #1 stated "just being lazy, and wanted to eat in room today." Resident #1 did not want to discuss alcohol related issues. Interview on 4/21/16 at 9:10 a.m. with Resident #1's Assistant Director of Nursing (ADON) revealed Resident #1's behavior was difficult to manage when he/she was intoxicated, and that the Resident had access to alcohol, as there was a liquor store located behind the facility. The ADON was not sure as to whether Resident #1 was a part of a treatment program. Follow-up interview on 4/22/16 at 9:30 a.m. with Resident #1's ADON confirmed the Resident was not a part of a treatment program to address his/her alcohol abuse. The ADON stated Resident #1's situation was recently discussed at a Behavioral Unit Meeting, and the Resident			

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
			consented to a referral for treatment. Observation on 4/21/16 at 2:30 p.m. outside the front door of the facility, and behind the benches revealed there was a 750 ml bottle of rum positioned between the brick structure and the bushes. Over half of the alcohol in the bottle had been consumed. S/S=D				
135	b. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	(M) Met					
136	§ 51.170 Dental Services. A facility: a. Must provide or obtain from an outside resource, in accordance with § 51.210 (h) of this part, routine and emergency dental services to meet the needs of each resident; b. May charge a resident an additional amount for routine and emergency dental services; c. Must, if necessary, assist the resident: 1. In making appointments; and 2. By arranging for transportation to and from the dental services; and 3. Promptly refer residents with lost or damaged dentures to a dentist.	(M) Met					
137	§ 51.180 Pharmacy services. The facility management must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 51.210 (h) of this part. The facility management must have a system for disseminating drug information to medical and nursing staff.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
145	b. Preventing spread of infection: 1. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. 2. The facility management must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. 3. The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	(P) Provisional Met	Based on observation, interview, and facility policy review, the facility failed to ensure that infection control practices were maintained to prevent the potential for infection and cross contamination for two (2) of 30 sampled residents (Residents #10, #19). The findings include: 1. Review of the medical record for Resident #10 revealed admission to the facility was on 10/22/14. Diagnoses included Dementia, Hypertension, Atrial Fibrillation, and Anemia. The admission nursing assessment dated 10/22/14 indicated the resident had intact skin. The minimum data set (MDS) assessment dated 1/28/16 indicated the resident was cognitively intact with some confusion. The MDS assessment also indicated the resident had a Stage 2 pressure sore on the right heel. An observation of wound care and dressing change for Resident #10 was conducted on 4/20/16 at 8:30 A.M. The Wound Care Nurse (WCN) gathered supplies and placed them on the bedside table without using a barrier or cleaning the table. The resident's brief was unfastened and assisted to turn over. The brief was soiled with stool and was pushed to the side to reveal a dime size red pressure sore over the resident's coccyx. The WCN did not clean the resident of stool or remove the soiled brief. Instead, he/she stated a caregiver would be notified of the need after the dressing was changed. The old dressing was removed and the wound was measured and then cleaned with wound cleanser and gauze. The WCN removed the soiled gloves and donned new gloves without washing his/her hands or performing hand hygiene. The WCN then removed the gloves, left the room, and returned with additional supplies. New gloves were donned without any hand washing or hand hygiene. After the new dressing was applied, the WCN fastened the soiled brief on the resident and then left the room.	<insert CAP details here>			

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
			2. Review of the medical record for Resident #19 revealed admission to the facility was on 2/17/16. Diagnoses included Atrial Fibrillation, Hypertension, Congestive Heart Failure, and Edema. The admission nursing assessment dated 2/17/16 revealed the resident's skin was intact. The MDS assessment dated 2/23/16 indicated the resident had moderate cognitive impairment. The resident ambulates with a walker and has some extremity impaired on the left. He/she requires assistance to transfer and re-position in bed. Review of the care plan dated 3/4/16 revealed a problem identified with newly acquired wounds on bilateral heels. An observation of wound care and dressing change for Resident #19 was conducted on 4/20/16 at 9:30 A.M. The WCN gathered supplies from the cart and placed them on the resident's dresser without using a barrier. The WCN removed scissors and gloves from his/her pocket and placed them on the bedside table without a barrier. After donning gloves, the nurse used the scissors to cut off the old dressing from the resident's left foot without cleaning the scissors. Five (5) wounds were identified on the left foot. The WCN stated he/she was aware of two (2) wounds but there were three (3) new ones that had not been previously assessed. The wounds on the left foot were measured. Wound cleanser was sprayed on all the wounds and wiped with gauze. The WCN removed the soiled gloves, opened the clean supplies, and then donned new gloves without performing hand washing or hand hygiene. The WCN then left the room and returned with more dressing supplies. The blue pad, which had been placed under the resident's foot, fell on the floor leaving the resident's open wounds resting on the bed spread. The WCN placed a new blue pad under the resident's foot and then removed the soiled gloves. New gloves were donned without performing hand washing or hand hygiene. All the				

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			wounds on the left foot were dressed and wrapped in gauze. Old gloves were removed and new gloves donned without any hand washing or hand hygiene. The WCN proceeded to cut off the old dressing from the right foot with the previously used scissors which had not been cleaned. Wound cleanser was sprayed on the right heel and wiped with gauze. The wound was re-dressed and the WCN left the room. Interview with the WCN on 4/20/16 at 9:45 A.M. revealed he/she was the only nurse for wound care in the entire facility and was having a tough time keeping up with all of it. The WCN indicated he/she did not want to leave the resident alone at the bedside to go to the sink for hand washing, and forgot to bring in a bottle of hand sanitizer. The facility did not have a policy/procedure for dressing changes. However, review of the policy for Universal Precautions reads: All health care workers should routinely use appropriate barrier precautions to prevent skin exposure during contact with any person's blood and body fluids. Gloves should be worn when touching blood and body fluids, mucous membranes, or non-intact skin. Gloves should be changed after contact with each member. Hands should be washed immediately after glove removal. S/S=D				
146	c. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
147	The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	(N) Not Met	147 (7-2), (7-3) This standard is not met as evidenced by; Based on record review and interview, the facility failed to maintain the automatic fire sprinkler systems, perform and document required inspection, testing, and maintenance services. The deficient practice affected all smoke compartments, staff and all residents. The facility has the capacity for 430 beds with a census of 371 on the days of survey. Findings include: 1. Record review of the facility sprinkler system inspection and test records on 04/20/16 at 11:30 a.m., revealed the facility was unable to provide a documented five (5) year internal pipe inspection service report for the building fire sprinkler systems. (7-2) Interview with the Fire Safety Supervisor and the Maintenance Supervisor on 04/20/16 at 11:35 a.m. revealed the facility was unaware of a requirement for internal pipe inspection services. 2. Record review of the facility sprinkler system inspection and test records for the 12 month period prior to the day of survey on 04/20/16 at 11:40 a.m., revealed the sprinkler system anti-freeze loop report provided no indication of a level degree of protection against freezing. (7-2) Interview with the Fire Safety Supervisor and the Maintenance Supervisor on 04/20/16 at 11:55 a.m. revealed the facility acknowledged no documented level of degree of protection. 3. Record review of the facility sprinkler system inspection and test records for the 12 month period prior	<insert CAP details here>			

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
			to the day of survey on 04/20/16 at 1:10 p.m., revealed during October 2015 an in-house inspection service report documented the fire sprinkler system "Post Indicator Valve" (PIV) for the McLeish building is inoperable and will not close. The facility was unable to provide a service report for corrections of noted deficiency. (7-2) Interview with the Fire Safety Supervisor and the Maintenance Supervisor on 04/20/16 at 1:15 p.m. revealed the facility acknowledged the in-house inspection deficiency report and also acknowledged no repairs had been made as of this survey. 4. Record review of the facility sprinkler system inspection and test records for the 12 month period prior to the day of survey on 04/20/16 at 1:30 p.m., revealed during October 2015 an in-house inspection service report documented the fire sprinkler system "Post Indicator Valve" (PIV) and tamper switch for the Mann building is damaged and does not provide a supervisory trouble signal at the facility's main alarm control panel (FACP). The facility was unable to provide a service report for corrections of noted deficiency. (7-3) Interview with the Fire Safety Supervisor and the Maintenance Supervisor on 04/20/16 at 1:35 p.m. revealed the facility acknowledged the in-house inspection deficiency report and also acknowledged no repairs had been made as of this survey. 5. Record review of the facility sprinkler system inspection and test records for the 12 month period prior to the day of survey on 04/20/16 at 1:45 p.m., revealed during October 2015 an in-house inspection service report documented the fire sprinkler system "Water Flow Device", 2nd floor Red wing stairwell of the Mann building failed to operate, has been replaced but not rewired to the fire			

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
			alarm system. The facility was unable to provide a service report for corrections of noted deficiency. (7-3) Interview with the Fire Safety Supervisor and the Maintenance Supervisor on 04/20/16 at 1:50 p.m. revealed the facility acknowledged the in-house inspection deficiency report and also acknowledged no repairs had been made as of this survey. 6. Record review of the facility sprinkler system inspection and test records for the 12 month period prior to the day of survey on 04/20/16 at 2:10 p.m., revealed during October 2015 an in-house inspection service report documented the fire sprinkler system "Tamper Valve Switch", 1nd floor, Red wing stairwell of the Mann building failed to operate. The facility was unable to provide a service report for corrections of noted deficiency. (7-3) Interview with the Fire Safety Supervisor and the Maintenance Supervisor on 04/20/16 at 2:23 p.m. revealed the facility acknowledged the in-house inspection deficiency report and also acknowledged no repairs had been made as of this survey. The census of 371 was verified by the Interim Director of Nursing on 04/19/16. The findings were acknowledged Interim Chief Operating Office and verified by the Interim Director of Nursing at the exit interview on 04/21/16. Actual NFPA Standard: NFPA 101, Life Safety Code (2012), Existing HealthCare Occupancies, Chapter 19. 19.3.5.1. Building containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.4. Actual NFPA Standard: NFPA 101 Life Safety Code (2102) Chapter 9,			

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			Building Service and Fire Protection Equipment. 9.7 Automatic Sprinklers and other Extinguishing Equipment 9.7.5 Maintenance and Testing, All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. Actual NFPA Standard: NFPA 25, (2011) Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 5.1 General. This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems Table 5.1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. 147 (3-3) Based on observation and interview, the facility failed to maintain the doors in the mean of egress. The deficient practice affected six (6) of nine (9) smoke compartments, staff and 55 residents. The facility has the capacity for 140 beds with a census of 140 the day of survey. This standard is not met as evidenced by; Findings include: 1. Observation on 04/20/16 at 09:35 a.m. revealed in the Rankin Building, 1st floor corridor emergency exit door to the elevator vestibule lobby swings against the direction of travel. This door is indicated on the facility emergency plan for evacuation, and has an illuminated exit signage installed. Interview with the Fire Safety			

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			Supervisor and Maintenance Supervisor on 04/20/16 at 09:40 a.m. revealed the facility was unaware of the door direction of travel. 2. Observation on 04/20/16 at 09:55 a.m. revealed in the Rankin Building, 1st floor corridor barrier door from the McLeish building to the Rankin building failed to close leaving only the minimum necessary opening for operations. Interview with the Fire Safety Supervisor and Maintenance Supervisor on 04/20/16 at 09:59 a.m. revealed the facility was unaware of the door opening issues. The census of 140 was verified by the Interim Director of Nursing on 04/19/16. The finding were acknowledged and verified by the Interim Chief Operating Office at the exit interview on 04/21/16. Actual Standard: NFPA 101 Life Safety Code (2012) Existing HealthCare Occupancies, Chapter 19. 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. Actual Standard NFPA 101 (2012) Chapter 7 Means of Egress, 7.1.10 Means of Egress Reliability. 7.1.10.1* General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1. Exit access shall be arranged that exits are readily accessible at all times. 7.2.1.4.2 Door Leaf Swing Direction. Door leaves required to be of the side-hinged or pivoted-swinging type shall swing in the direction of egress travel under any of the following			

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			conditions: (1) Where serving a room or area with an occupant load of 50 or more, except under any of the following conditions: (a) Door leaves in horizontal exits shall not be required to swing in the direction of egress travel where permitted by 7.2.4.3.8.1 or 7.2.4.3.8.2. (b) Door leaves in smoke barriers shall not be required to swing in the direction of egress travel in existing health care occupancies, as provided in Chapter 19. (2) Where the door assembly is used in an exit enclosure, unless the door opening serves an individual living unit that opens directly into an exit enclosure (3) Where the door opening serves a high hazard contents 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. 19.3.7.9 Door openings in smoke barriers shall be protected using one of the following methods: (1) Swinging door providing a clear width of not less than 32 in. (810 mm) (2) Horizontal-sliding door complying with 7.2.1.14 and providing a clear width of not less than 32 in. (810 mm) 8.5.4 Opening Protectives. 8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3/4 in. (19 mm). S/S=F				

Department of Veterans Affairs - (Standards - Domiciliary)

SURVEY CLASS	SURVEY YEAR	COMPLETION DATE
Annual Survey	2016	4/22/2016

NAME OF FACILITY	STREET ADDRESS	CITY	STATE	ZIP CODE
Grand RapidsD	3000 Monroe Ave. N.E.	Grand Rapids	MI	49505

SURVEYED BY (VHA Field Activity of Jurisdiction)

Carrie Storms2 Cynthia thompson_gra Damien Wilson Juan T Herrera Kirk Watson_FU Kristin Allen_gra Laura Jacobsen_gra Lisa Martin Nomie Wallace_gra
Patrick Fleming2 Susan Honaker

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING/ DATE
159	1. Governance and Operation The facility is governed and managed effectively. A. The facility has a governing body or designated persons so functioning with full legal authority and responsibility for the operation of the facility.	(M) Met					
160	B. Written administrative policies, procedures, and controls are established, implemented and reviewed at least annually to promote the orderly and efficient management of the facility.	(M) Met					
161	C. There are sufficient, knowledgeable administrative and clinical staff assigned to provide quality care within the domiciliary.	(P) Provisional Met	Since the 2015 Survey, the staffing at the Domiciliary has been decreased by 2 full time positions (one RN and one Admin Support staff). This leaves one RN to handles concerns related to 41 members. After 6:30pm and on weekends, members residing at the Domiciliary have to find staff on other medical units to obtain assistance. S/S=D	<insert CAP details here>			
162	D. Written personnel policies and procedures are established and implemented to facilitate sound patient care and personnel practices.	(M) Met	This standard is met with a recommendations to establish guidelines on hygiene and self care. Written procedures should be developed and published for residents on actions to take in case of medical emergencies, fire, and disaster response.				
163	E. The facility has an ongoing staff development program including orientation of new employees and inservice education related to the needs and care of domiciliary patients.	(M) Met	This standard is met with a recommendation as no staff orientation is available for working in Domiciliary. Procedures should be developed and maintained at the location and staff be trained prior to assignment.				

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198	C. Results of social services rendered are documented in the patient's medical record.	(N) Not Met	Based record review, interview, and review of facility policy, it was determined the facility failed to have the results of social services documented in five (5) residents medical records. The findings include: Based record review, interview, and review of facility policy, it was determined the facility failed to have the results of social services documented in five (5) residents medical records. The findings include: The facility's Domiciliary policy for social work documentation (07-01-11), states that "(m)embers who reside in Domiciliary care shall receive an Interdisciplinary Care Assessment within fourteen (14) days of admission, and thereafter six months or sooner, as needed to determine the functioning needs and care needs....". A random review within the Domiciliary (Rankin 3) conducted on April 21, 2016 of five current medical records (31291, 31794, 28937, 24689, and 31939 - both paper and electric medical record), revealed that these medical records did not contain any notation by social work staff beyond September, 2015. The social worker assigned to cover the Domiciliary unit stated in interview on April 22, 2016, "I was directed in February 2016 to take on the Domiciliary unit in addition to my other unit responsibilities in the nursing facility. The Domiciliary social worker is currently away on maternity leave. I was unaware of the facility policy and was never informed that the Domiciliary residents had to have updated written assessments on an on-going basis". Accordingly, the facility did not meet its own standard 07-01-11 for timely social work updated interventions. S/S=F	<insert CAP details here>			
199	D. The facility has an organized procedure for discharge and transfers.	(M) Met					

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213	10. Pharmacy. Pharmaceutical services meet the needs of patients and are provided in accordance with ethical and professional practices and legal requirements. A. A registered pharmacist is responsible for pharmacy services.	(M) Met					
214	B. A program is established for the safe procurement, control, and distribution of drugs.	(M) Met					
215	C. There is controlled access to all drugs and substances used for treatment.	(M) Met					
216	D. Patient on self-medication are instructed by qualified personnel on the proper use of drugs	(M) Met					
217	E. Provision is made for qualified nursing personnel to administer medication to patients who are not in a self-medication program.	(M) Met					
218	F. There is an established system for monitoring the outcome of drug therapy or treatment.	(M) Met					
219	11. Medical Records. The patient's health status is documented regularly in the medical record in accordance with the treatment plan. A. Medical records are completely legible and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.	(M) Met	Recommendation: While it is recognized that Domiciliary residents independently take prescribed medications, those medications should be incorporated in the electronic medical record for continuity of care.				
220	B. The facility safeguards medical record information against less, destruction or unauthorized use.	(M) Met					
221	C. The medical record contains sufficient information to clearly identify the patient.	(M) Met					
222	12. Quality Assistance. The facility has an active quality assurance program in the domiciliary to ensure efffective utilization and delivery of patient care services.A. A member of the facilities staff or facility committee is designated as responsible for coordinating the quality assurance program.	(N) Not Met	There was no evidence of a quality assurance program and related documentation. The only staff member assigned to work in the Domiciliary was unaware of the existence of a quality assurance program. S/S=F	<insert CAP details here>			
223	B. The quality assurance program emcompasses reviews of all services and programs provided for the domiciliary patients.	(N) Not Met	There was no evidence of a quality assurance program and related documentation. S/S=F	<insert CAP details here>			
224	C. The quality assurance program encompasses ongoing utilization review.	(N) Not Met	There was no evidence of a quality assurance program and related documentation. S/S=F	<insert CAP details here>			

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225	D. The quality assurance program is revaluated at least annually.	(N) Not Met	There was no evidence of a quality assurance program and related documentation. S/S=F	<insert CAP details here>			
226	13. Quality of Life. The domiciliary level of care fosters a quality of life conductive to self esteem, security, and personal growth. A. Patients are treated with respect and dignity.	(M) Met					
227	B. There is input to the domiciliary program through a patient advisory council.	(M) Met					
228	C. A homelike environment is provided.	(M) Met					
229	D. The facility has written policies and procedures concerning the rights and responsibilities of the domiciliary patient.	(M) Met					
230	E. Patients are oriented to the policies and procedures of the domiciliary on admission.	(M) Met					
231	F. Patients may manage personal financial affairs or are given an accounting as required by state law, of financial transactions made on their behalf.	(M) Met					