STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235021	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chelsea Retirement Community	805 W Middle St Chelsea, MI 48118

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to coordinate with the appropriate, State-designated authority, to ensure that 1 of 2 residents (R34) reviewed received timely follow-up PASSAR II evaluations and coordination of care, resulting in the delay in mental health services appropriate to their needs. Findings include: Resident #34 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R34 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included major depression, generalized anxiety, bipolar disorder, unspecified dementia, frequent falls and epilepsy. Review of the Pre-Admission Screening And Resident Review (PASARR) Level I, dated 6/10/24, reflected R34 had marked yes for the person has current diagnosis and received treatment for mental illness and has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. The PASARR reflected R34 had diagnosis of Bipolar and was taking Ability, Vistaryl, Lexapro and Lamictal. Continued review of the level 1 PASARR reflected, DISTRIBUTION: If any answer to items 1 - 6 in SECTION II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative. Review of the Electronic Medial Record(EMR), dated 6/13/24 through 8/7/24, reflected no evidence of Level 2 PASSAR. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During in interview on 8/07/24 at 2:32 PM, Social Worker F reported R34 had a competed Level 1 PASARR that reflected the need for PASARR Level 2 to be completed. SW F reported facility either has the level 2 or a letter that one had been completed. SW F reported was able to locate letter for R34 from the Department of Health and Human Services that PAD-OBRA Level 2 Evaluation was completed and made a recommendation on placement and services. The letter reflected, Determination: Nursing Facility - Other Mental Health Services. The individual qualifies for the level of services provided by a nursing facility and does not require specialized mental health/developmental disabilities services but may need other mental health/developmental disabilities services . SW F reported R34 had not been seen by mental health services and did not have a referral but could send one. SW F reported facility had to petition for guardianship for R34 and was appointed emergency guardian 7/18/24. SW F verified R34 signed consents including consents for antipsychotic on 6/13/24 and was seen by first provider for capacity on 6/14/24 and second on 6/17/24 deemed incapable to make health choices. SW F reported consents should be completed by emergency guardian. Review of the Provider Visit note, dated 7/2/24, reflected plan that R34 should be considered for referral to in house psychiatric care. Review of R34 Provider Visit Note, dated 7/16/24, reflected, Bipolar 1 disorder(CMS/HCC) No change in medications, will make psychiatric referral if patient continues to stay long-term. Review of R34 Physician Orders, dated 7/9/24, reflected, psych evaluation for medication management and therapy one time only for bipolar disorder During an interview on 8/07/24 at 4:05 PM, SW F provided R34 level 2 PASARR and OBRA assessment completed just prior to admission at this facility that reflected mental health services needed. SW F verified provider note, dated 7/16/24, reflected plan for mental health consult and reported should have been completed after emergency guardian obtained 7/18/24. SW F reported was not aware of need for referral and reported usually notified by nursing or provider. SW F reported mental health service plan to be at facility tomorrow and will plan to have R34 on list to be seen. Review of the Preadmission Screening Comprehensive Level 2 Evaluation, dated 6/12/24, reflected R34 was marked for mental illness. The Evaluation included diagnosis of Major depressive disorder, recurrent episode. with psychotic features-primary, post-traumatic stress disorder, and generalized anxiety disorder. The evaluation recommended Nursing Facility/Other Mental Health Services including Individual therapy and psychiatric medication review. Continued review of the evaluation reflected, Historically , [named R34] does not manage stress, triggers, or symptoms well and would frequently experience suicidal ideation's. This often led to psychiatric treatment/hospitalization s. [Named R34] should be closely monitored of any signs and symptoms of increased depression, which may include but is not limited to: tearfulness, agitation, lack of appetite, sleep disturbance .[named R34 does have history of psychosis along with depression and should also be monitored for paranoia, delusions, suspicions, and hallucinations. Any evidence of signs or symptoms should be reported to [named R34] treatment team immediately .[named R34] should be connected to appropriate mental health services while admitted to the nursing facility, such as the facility's contracted mental health provider. [named R34] would benefit from talk therapy and psychiatric medication review . During an interview on 8/8/24 at 1:10 p.m., SW F reported admission staff should have obtained PASSAR Level 2 on admission for any resident major mental health diagnosis including for R34 with diagnosis of Bipolar. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility, PASARR Coordination Program, undated, reflected, The Social Services Department shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 Based on observation, interview and record review, the facility failed to implement care plan interventions for one of 18 residents reviewed for care plans (Resident #52), resulting in the likelihood of aspiration of food or liquid into the lungs and choking during meals. Findings include: Resident #52 (R52) On 8/06/2024 at 12:36 PM, R52 was observed sitting in a chair in her room eating lunch. A male friend was sitting next to her and stated R52 could not talk, but could shake her head yes or no. R52's care plan dated 6/29/2024 instructed not to share or speak with R52 about medical Information with male visitor present; he was just a friend, and ask him to leave first per family. R52's nutrition at risk care plan dated 7/02/2024 revealed a dysphagia 3 diet (moist, chopped/bite-sized pieces) was ordered and she required full one to one supervision with meals. R52's Minimum Data Set (MDS) with assessment reference date of 7/03/2024, revealed she was admitted to the facility on [DATE] and her cognitive skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). R52's same MDS revealed R52 had signs and symptoms of a swallowing disorder including holding food in mouth/cheeks or residual food in mouth after meals; and coughing or choking during meals or when swallowing medications. R52's same MDS, under care area assessment (CAA), indicated she was recently hospitalized for a stroke and had aphasia (language disorder, may have trouble understanding, speaking, reading or writing). R52's same CAA indicated was to have one to one, full supervision with meals. In review of speech therapy notes dated 8/01/2024, R52 required skilled services for dysphagia to assess and determine least restrictive diet and develop and instruct in compensatory strategies; to enhance her quality of life, by improving ability to safely swallow without signs/symptoms of aspiration. It was determined R52's difficulties learning new information would impact her treatment. In review of speech therapy notes dated 8/05/2024, R52's goal was to tolerate her diet with no overt signs or symptoms of aspiration/pulmonary (lung) compromise with use of safe swallowing strategies and cues. Progress on R52's goal dated 8/05/2024 indicated she had an intermittent cough with thin liquids, and benefited from alternating liquids/solids to aid in timing of oral clearance/swallow initiation. Alternating liquids/solids was not included in R52's care plan or in the kardex (nurse assistant care plan instructions). Physician Progress Note dated 8/06/2024 revealed R52 was seen for follow-up and was now able to speak a few words on occasion. R52 communicated she still had a poor appetite, needed assistance with eating, and was messy at times. The same note indicated R52 had lost five pounds over the last three weeks and staff were encouraging her to eat snacks whenever possible. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R52's speech therapy recommendations dated 8/07/2024 included: one to one supervision, slow rate, small bites and sips, sit upright, alternate liquids and solids and ensure oral cavity was clear following meals. Instructions including slow rate, small bites and sips, sitting upright, were not included in R52's care plan or kardex. On 8/07/2024 at 8:17 AM, R52 was observed lying in bed with the head of her bed elevated in a reclined position. R52's breakfast tray was placed on a table to the right of her bed with the cover on, and juice uncovered. Later, on 8/07/2024 at 8:54 AM, R52 was observed sitting in her room in a dining chair eating breakfast placed on a table directly in front of her. No staff were observed assisting or supervising her during her breakfast meal. On 8/07/2024 at 12:19 PM R52 was observed sitting in a chair in room eating lunch. R52's male friend was the only person in her room, no staff were present. On 8/08/2024 at 12:05 PM R52 was observed sitting in her room eating lunch unassisted, no staff, friends or family were present. Certified Nurse Assistant (CNA) O was interviewed on 8/08/2024 at 12:19 PM and stated she thought R52 was no longer one to one supervision with meals . Rehabilitation Director P was interviewed on 8/08/2024 at 12:33 PM and stated she had verified with Occupational Therapy and Speech Therapy that recommendations for one to one supervision with meals continued to be recommended for R52's care.