

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Bay Bluffs-Emmet CO Med Care Fac		STREET ADDRESS, CITY, STATE, ZIP CODE  750 E Main Harbor Springs, MI 49740	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40383</p> <p>Based on observation, interview, and record review, the facility failed to ensure supervision and safety for one Resident (R162) of two residents reviewed for unsafe wandering. This deficient practice resulted in R162 wandering into a non-resident area where chemicals were located and fell . Findings include:</p> <p>The Fall Report labeled Unwitnessed Date: 4/15/2024 00:00 (Midnight) gave an Incident Description: as follows: This nurse was off hallway to retrieve medication . CNA (Certified Nurse Aide) called writer during this time stating resident was in (sic) floor. Upon entering hallway, resident was observed lying on left side in janitor's closet facing towards back wall with head between mop bucket and shelf. Resident had pants pulled down and had urinated in (sic) floor. Her w/c (wheelchair) was outside of med (medication) room door. She is unable to appropriately describe incident to staff members r/t (related to) her dementia. Gripper socks were in place at time of incident. The Immediate Action Taken was documented as follows: .resident assessed for injuries; mild redness noted to left side of face but resident denied any pain . Janitor's closet door assessed and it is noted that although this door has keypad for entry, it can be opened without entering passcode . Maintenance to be notified via Worx (electronic work order system) Hub re: janitor's closet door not locking</p> <p>The electronic medical record (EMR) progress note dated as 4/16/24 Late Entry read in part: .fall occurred in unit hallway at midnight with minor injury. Unit CNA reports that, Me and (CNA named) were finishing up our midnight rounds, we had come out and saw (R162) car (wheelchair) sitting empty. We checked residents (sic) rooms/kitchen and lastly checked janitors closet because it's supposed to be locked. We saw her on the ground pants off laying on back/left side with urine on the ground. Her head was between the mop bucket and shelf. Wing nurse further reports that resident was lying on her left side . This nurse able to view camera footage leading up to incident. Resident observed at 2330 (11:30 PM) in wheelchair, propelling self in area around nursing station. In/out of dining room and transferring out of wheelchair multiple times . All staff leave the nursing station just before 2357 (11:57 PM) . She pushed her pants down around her thighs . she shuffled back along the handrail until she got to the closet door. Using the knob, the door opened easily and the light automatically triggered as resident stepped inside. At 00035 (12:03.5 AM) she is observed closing the door behind her . Resident admitted to the facility on ,d+[DATE] for LTC (Long Term Care) from (named facility). Had fallen at home on 02-07 sustaining a fracture to upper end of her L (left) humerus (upper arm) . Resident is pleasantly confused; unable to recall safety interventions.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/17/24 at 8:38 AM, the Nursing Home Administrator (NHA) discussed the incident and stated the halls were monitored with cameras and the video timeline revealed R162 was in the janitor's closet for 3.5 minutes.</p> <p>On 04/17/24 at 10:07 AM, the video footage was observed with the Director of Nursing (DON) and the timeline listed in the late entry progress note of 4/16/24 above was confirmed regarding the event on 4/15/24. R162 left her wheelchair, ambulated to several doors, pulled her pants down below her knees, and came to the janitor's closet and was able to enter the closet. The video footage confirms R162 was in the closet unattended for approximately 3.5 minutes.</p> <p>A review of R162's medical record, revealed admission to the facility on [DATE] with diagnoses including Alzheimer's disease, fracture of the left arm, cognitive communication deficit, stroke, and dementia. The fall risk assessment upon admission indicated R162 had a history of falling with a high-risk score for falls of 65. (Scores over 45 are high risk.) The Minimum Data Set (MDS) assessment dated [DATE] documented R162 had a fall with fracture within the last 2-4 months prior to admission and used a wander/elopement alarm daily. The care plan for R162 included:</p> <ul style="list-style-type: none"> <li>- I am a high risk to wander. I have Dementia and have been taken out of my environment. Date Initiated: 03/27/2024</li> <li>- Please keep me safe when I wander. Date Initiated: 03/27/2024.</li> <li>- Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, books. Date Initiated: 03/27/2024.</li> <li>- Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date Initiated: 03/27/2024.</li> <li>- WANDER ALERT: right ankle. Check for placement and light flashing every shift. Date Initiated: 03/27/2024.</li> <li>- I have an ADL (Activities of Daily Living) self-care performance deficit r/t Alzheimer's disease along with a history of a CVA (stroke) with RT (right) sided weakness. I recently had a fall with a LUE (left upper extremity ) fracture. Date Initiated: 03/26/2024.</li> </ul> <p>During an interview on 4/15/24 at 12:53 PM, CNA D stated R162 had a one on one today (a staff member assigned to only R162) due to getting out of bed and she was a fall risk.</p> <p>During an interview on 4/17/24 at 10:18 AM, the DON stated it was discovered the janitor storeroom was accessed by R162 when she randomly pushed the lock buttons.</p> <p>On 4/17/24 at 8:40 AM, the Director of Housekeeping/Laundry (Staff A) accompanied this surveyor on a tour of the building checking the doors assessed to need locks to ensure the safety of the residents. The janitor closet where R162 had accessed and fallen contained two chemical products:</p> <ul style="list-style-type: none"> <li>- A disinfectant with MSDS (Material Safety Data Sheet) warnings of eye irritant and</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- An odor eliminator available with MSDS warnings of Keep out of reach of children. All individual ingredients of this material have a known acute toxicity.</p> <p>During the lock checking facility tour on 4/17/24 at 9:02 AM, the lock on the kitchen storage room door was determined to be faulty. When the door was checked, it was not locked per coded badge swipe lock but was able to be easily pushed open.</p> <p>During the lock checking facility tour on 4/17/24 at 9:18 AM, the lock on the maintenance storage room with keypad was determined to be faulty. This room stored several hazardous chemical industrial use containers including ice [NAME], spot and stain remover, spray buffing solution, floor sealer, soil extractor carpet cleaner, and stone, tile, and grout sealer. Staff A observed the condition of the room with faulty lock and multiple hazardous chemical agents and said, It is dangerous for sure.</p> <p>During an interview regarding the maintenance door failing to lock on 4/17/24 at 9:51 AM, CNA D stated the door preceding the door in question did not have a lock. This door was alarmed by a wander guarded system whereby those wearing a protective device would trigger the locking of the preceding door.</p> <p>During an interview on 4/17/24 at 12:14 PM, Registered Nurse (RN) E reviewed the current MDS triggered report and stated the unit with the unlocked maintenance storage door and unlocked preceding door had 15 residents on that unit who had a diagnosis of dementia or Alzheimer's disease. RN E said, We have to have the diagnosis and physician acknowledgment of dementia or Alzheimer's Disease prior to completing the MDS. Of the 15 residents on that unit coded with dementia or Alzheimer's Disease, only one resident wore a protective device which would trigger the preceding door to be locked.</p> <p>The facility policy Hazardous Areas, Devices and Equipment dated 4/16/24 read in part, All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible . A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples include . g. Access to toxic chemicals . k. Disabled locks, latches, or alarms.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49310</p> <p>Based on observation, interview, and record review, the facility failed to prevent unauthorized access to the facility's three medication storage rooms by allowing unlicensed personnel to retain keys and access the three medication storage rooms. Findings include:</p> <p>On 4/17/24 at 8:55 a.m., 9:05 a.m., and 9:11 a.m., the Housekeeping Supervisor, Staff A, was observed using a magnetic swipe-card to enter three medication storage rooms without a licensed nurse in attendance. When questioned regarding access to medication storage rooms, Staff A said the housekeeping staff had magnetic-swipe cards to access the medication storage rooms for cleaning of the rooms.</p> <p>Medication storage audits were conducted on the 200 unit and 500 unit medication storage rooms on 4/17/24 at 9:43 a.m. Ophthalmic solutions, insulins, syringes, over-the-counter medications, and biological agents were observed in the medication storage rooms.</p> <p>Staff B was observed utilizing a magnetic swipe-card to enter the medication storage room on the 200 unit on 4/17/24 at 12:14 p.m. Staff B confirmed she was a housekeeper and said the building had three medication storage rooms. Staff B said, all housekeepers have access to the med rooms to clean them. Staff B confirmed the housekeepers were not accompanied by nurses when accessing and cleaning the medication rooms.</p> <p>Registered Nurse (RN) C was interviewed on 4/17/24 at 12:20 p.m. regarding the housekeepers' access to medication storage rooms. RN C confirmed housekeepers accessed the three medication rooms in the facility and the nurses were not required to accompany housekeepers during the cleaning tasks in the medication storage rooms.</p> <p>During an interview with the Nursing Home Administrator (NHA) on 4/17/24 at 12:42 p.m., the NHA was asked regarding staff access to the medication storage rooms. The NHA stated, Only nurses should have access to med rooms. When told the housekeeping staff have magnetic swipe-cards to enter the medication storage rooms, the NHA appeared surprised and said she was not aware of anyone having access to medication storage areas aside from licensed nursing personnel.</p> <p>The Director of Nursing (DON) was interviewed on 4/17/24 at 12:58 p.m. When asked regarding medication storage room access, the DON said the nurses and DON had access to those areas. When asked if housekeepers had access to the medication storage rooms, the DON stated, I don't think so - I think the nurses need to let them in, but I'm not sure.</p> <p>The policy 'Storage of Medications' dated 12/13/23 read in part: (name of facility) shall store all drugs and biologicals in a safe, secure, and orderly manner. 10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys.</p>		