STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235052	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aberdeen Rehabilitation and Skilled Nursing Center	5500 Fort St Trenton, MI 48183

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 Based on interview and record review the facility failed to obtain and address Medication Regimen Review (MRR) recommendations timely for two residents (R3 and R12) of five residents reviewed for medication regimen review, resulting in the potential for the continuance of unnecessary medications and lack of communication of recommended medication changes between pharmacist and physician. Findings include: R12: On 8/24/24 at 11:14 a.m. review of the clinical record documented R12 was admitted into the facility on [DATE] with diagnoses that included diabetes mellitus, type 2, acute respiratory failure with hypoxia, congestive heart failure, dementia, and asthma. According to the quarterly Minimum Data Set (MDS) dated [DATE], R12 had moderate cognitive impairment and dependent for most activities of daily living. Review of R12's physician orders documented the resident's current medications as follows: - Basaglar Kwik Pen U-100 Insulin (insulin glargine) 100 unit/mL (3 mL) inject 33 units subcutaneous daily. Start date 8/13/24. - Insulin Aspart U (Novolog)-100 unit/ml inject 8 units subcutaneous twice a day. Start date 7/12/24. - Metformin 1000 mg oral twice a day. Start date 6/6/24. Review of monthly pharmacy recommendations in the electronic medical record documented the following: -3/19/24- Pharmacist Drug Regimen Review . Please take the following action described below . See report: (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note to Attending Physician/Prescriber: This resident is currently on a sliding scale coverage with Novolog insulin. Recent AGS Beers Criteria suggest avoiding the use of a sliding scale insulin due to the risk of hypoglycemia without improvement in hyperglycemia management. Please evaluate if this patient may benefit from the addition of a long-acting insulin or an increase in their current medications. If the sliding scale insulin is continued, please provide documentation to support therapy. Response: 1. Change sliding scale Insulin to . 2. Continue sliding scale insulin. The benefits outweigh the risks. The Physician/Prescriber Response was blank. There was no documented response from the facility. -4/2/24- Pharmacist Drug Regimen Review. There was no Recommendation made by facility. -5/6/24- Pharmacist Drug Regimen Review. There was no Recommendation made by facility. On 8/28/24 at 2:05 p.m. the Director of Nursing (DON) submitted an email from the pharmacist dated 8/28/24 at 1:33 p.m. the pharmacy recommendation for 3/19/24 was attempted to be updated in the electronic medical record. The DON said the recommendation had not been addressed because it was missed. 22349 R3: According to R3's Electronic Health Record (EHR) the resident admitted to the facility with multiple diagnoses that included Intellectual Disabilities and altered Mental Status. The Pharmacist's Drug Reviews dated 5/6/24 and 7/2/24 indicated there were pharmacy recommendations and documented; Please take the following action described below. There was no further documentation to describe the recommendation of action from the Pharmacist. On 8/28/24 at approximately 1:00 PM the Director of Nursing (DON) was asked where the Pharmacist's recommendations for R3 were. The DON reported that they were located in an office and were not part of the clinical record. The DON could not produce or determine what the pharmacist's recommendations on 5/6/24 or 7/2/24 for R3 were at this time. On 8/28/24 at 3:30 PM the Regional Director of Operations (RDO) said the facility could not locate the actual Pharmacist's recommendations and the pharmacy was requested to fax them over to the facility. The RDO said, The Pharmacist reports and recommendations should be part of the resident's medical record and the physician should be notified of them. On 8/29/24 at 9:00 AM the DON provided R3's pharmacy recommendations for 5/6/24 and 7/2/24. The pharmacy recommendation for 5/6/24 did not have any notation or signature by the physician or a physician extender to indicate they had been notified of the recommendations. Review of the facility's policy titled, Pharmacy Medication Review revision date 8/2021 documented in part the following: Guidelines: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The MRR should be conducted by a pharmacist with specialized training and clinical expertise to perform medication reviews. 2. The Medical Records Designee is responsible to the Director of Nursing for maintaining the Medical Records program. 3. The intent of a MRR is to address any clinically significant medication issues in a timely manner. Procedure: 1. The MRR will be completed by a pharmacist on a monthly basis and as needed or required. 2. The pharmacist will submit a recommendation for each resident reviewed. 3. The recommendation will be submitted via email to the Director of Nursing (DON) and the Medical Records Designee within 48-72 hours of the review. 4. The Medical Records Designee will place all pharmacy recommendations on the attending physician's clipboard for review. 5. The physician/physician extender may agree or disagree with the pharmacy recommendation and must sign off on all recommendations. Once the pharmacy recommendation has been signed, a medication order must be created and added to the resident's Medication Administration Record (MAR), once the order is added the document should be returned to the attending physician ' s clipboard to be uploaded into the resident's EHR, by the Medical Records Designee. The Physician is required to provide a rationale for not agreeing with any pharmacy recommendations, and the rationale must be documented in a progress note or on the pharmacy recommendation 7. The Medical Records Designee is responsible for reporting any discrepancies/concerns to the DON and/or Medical Director in a timely manner, all emergency matters should be reported immediately. 8. The DON is responsible for overseeing the Pharmacy Recommendation process and reporting any discrepancies/concerns to the Medical Director and Administrator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on interview and record review, the facility failed to maintain complete and accurate medical records for two (R3 and R12) of 15 residents reviewed for medical records, resulting in resident's pharmacy recommendations being unclear and not maintained in the resident's Electronic Health Record (EHR) with the potential for miscommunication of pharmacy recommendations, physician's orders, and an unclear picture of the resident's health care status. Findings include: R3: According to R3's Electronic Health Record (EHR) the resident admitted to the facility with multiple diagnoses that included Intellectual Disabilities and altered Mental Status. The Pharmacist's Drug Reviews dated 5/6/24 and 7/2/24 indicated there were pharmacy recommendations and documented; Please take the following action described below. There was no further documentation to describe the recommendation of action from the Pharmacist. On 8/28/24 at approximately 1:00 PM the Director of Nursing (DON) was asked where the Pharmacist's recommendations for R3 were. The DON reported that they were located in an office and were not part of the clinical record. The DON could not produce or determine what the pharmacist's recommendations for R3 were at this time. On 8/28/24 at 3:30 PM the Regional Director of Operations (RDO) said the facility could not locate the actual Pharmacist's recommendations and the pharmacy was requested to fax them over to the facility. The RDO said, The Pharmacist's reports and recommendations should be part of the resident's medical record. According to the facility's Pharmacy Medication Review policy last revised 8/2021 in part reads; Purpose: The purpose of a Pharmacy Medication Regimen Review (MRR) is to identify Medication-related problems and to provide a safe and effective medication treatment plan for all residents. Pharmacy recommendations will provide guidance to the interdisciplinary team and a thorough evaluation of the medication regimen for each resident, with the goal of promoting positive outcomes and minimizing adverse consequences related to medications. The review should include preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities as well as collaboration with other members of the interdisciplinary team. Procedure: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. The physician/physician extender may agree or disagree with the pharmacy recommendation and must sign off on all recommendations. Once the pharmacy recommendation has been signed, a medication order must be created and added to the resident ' s Medication Administration Record (MAR), once the order is added the document should be returned to the attending physician ' s clipboard to be uploaded into the resident ' s EHR, by the Medical Records Designee. The Physician is required to provide a rationale for not agreeing with any pharmacy recommendations, and the rationale must be documented in a progress note or on the pharmacy recommendation. 38230 R12: On 8/24/24 at 11:14 a.m. review of the clinical record documented R12 was admitted into the facility on [DATE] with diagnoses that included diabetes mellitus, type 2, acute respiratory failure with hypoxia, congestive heart failure, dementia, and asthma. According to the quarterly Minimum Data Set (MDS) dated [DATE], R12 had moderate cognitive impairment and dependent for most activities of daily living. Review of monthly pharmacy recommendations in the electronic medical record documented the following: 3/19/24- Pharmacist Drug Regimen Review . Please take the following action described below . See report. 6/4/24- Pharmacist Drug Regimen Review . Please take the following action described below . See report. The pharmacy recommendation reports were not readily available in the electronic medical record and the facility had to search for them. On 8/28/24 at 2:05 p.m. the Director of Nursing (DON) submitted an email from the pharmacist dated 8/28/24 at 1:33 p.m. for the pharmacy recommendation dated 3/19/24 that read an attempt was made to update in the electronic medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on observation, interview, and record review the facility failed to practice proper infection control techniques for one (R4) of one resident reviewed with enhanced barrier precautions, resulting in the potential for widespread infection. Findings include: 08/28/24 at 2:15 PM, R4 was observed to be returned to bed for brief changed and wound care. Registered Nurse, (RN) O and Certified Nursing Assistant, (CNA) S were observed to perform care on R4 without wearing a gown. Review of R4 Electronic Medical Record, (EMR) noted an admitted to the facility on [DATE] with a pertinent diagnosis of Stage II to buttocks. R4's Brief Interview of Mental Status, (BIMS) score was 14/15 (intact cognition). 08/28/24 at 2:25 PM, RN O was interviewed and acknowledged staff should have been wearing a gown. Unit Manager, UM R was interviewed and added there was a sign on the door and the staff should have been wearing a gown when performing change of brief as well as wound care.