

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Manor Senior Care Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Evergreen Battle Creek, MI 49015	

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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>45038</p> <p>Based on observation, interview, and record review the facility failed to provide and document evidence of prompt resolution to a grievance for missing personal clothing of one (resident #48) out of one resident reviewed resulting in unresolved grievance.</p> <p>Findings Included:</p> <p>Resident #48 (R48)</p> <p>Review of the medical record revealed R48 was admitted to the facility 12/06/24 with diagnoses that included sepsis (complicated infection), cellulitis (bacterial skin infection) of left lower limb, chronic pain syndrome, depression, gastro-esophageal reflux, hypertension, neuropathy (pain from nerve damage), osteoarthritis (degenerative joint disease), rheumatoid arthritis (chronic inflammation of joints), spinal stenosis(spinal narrowing), obesity, lymphedema (swelling of extremities cause by lymphatic system blockage), and difficulty walking. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.</p> <p>During observation and interview 01/13/2025 at 02:01 p.m. R48 was observed sitting up in a reclining chair in her room. R48 explained that she was missing a blue pair of pants. R48 explained that she had told a Certified Nurse Aide (CNA) sometime last week but could not recall the exact date or time. R48 explained that the blue pants still had not been located. R48 denied that she had been offered to complete a Resident Assistance Form.</p> <p>During review of the facilities concern log, which included concerns for the last 90 days, had not demonstrate that R48 had completed a concern form regarding a pair of blue pants.</p> <p>During an interview on 01/14/2025 at 10:11 a.m. Certified Nurse Aide (CNA) I explained that she was the CNA that was providing care to R48 today. She explained that she frequently provides care to R48 and had lost worked with her the previous week. CNA I was asked if R48 had reported to her that she was missing any clothing items. CNA I explained that R48 had informed her that she was missing a blue pair of pants sometime last week. CNA I explained that she could not locate the pants that day and had not completed or offered R48 to complete a Resident Assistance Form. CNA I explained that she had not reported the missing item of clothing to another facility staff member.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/14/2025 at 10:27 a.m. Director of Nursing (DON) B explained that if residents reported missing clothing to staff, it would be the expectation and policy that the staff either provide the resident with a Resident Assistance Form or they assist the resident in completing a Resident Assistance Form. DON B explained that the Resident Assistance Form would be given to the Nursing Home Administrator (NHA) A. DON B explained that then someone from laundry would attempt to locate the missing clothing and a response would be provided in writing to the resident. DON B could not provide information if R48 was missing any clothing items.</p> <p>During an Interview on 01/14/2025 at 10:33 a.m. Nursing Home Administrator (NHA) A explained that it was the facility policy and her expectation that when residents reported missing clothing that a Resident Assistance Form be provided by staff or staff assisted the residents to complete a Resident Assistance Form. The complete form then would be provided to her and an investigation to locate the items would be conducted. NHA A explained that she always expected staff to provide a Resident Assistance Form with any resident issues were reported because it allowed her to track and trend concerns in the facility. NHA A denied that she had knowledge of R48's missing blue pants and could not provide a Resident Assistance Form for R48's missing pants. NHA A explained that a concerns form would be completed as soon as possible and the process of locating the item would be started.</p> <p>Review of policy entitled Resident Concern Policy- ADM-155D, original date of 08/31/2015 and revision date of 11/14/2023, revealed the following procedure:</p> <p>Step 1. Tell your grievance (s) to one of the individuals list below:</p> <ul style="list-style-type: none"> - Director of Nursing - Administrator (Grievance Official) - Social Services Director - Charge Nurse (if after hours) <p>Step 2. If you are not satisfied with the staff person's response, please complete our Resident Assistance Form. Let us know if you need help in completing the form.</p> <p>Step 3. Submit the form to our Administrator or Director of Nursing.</p> <p>Step 4. If you are not satisfied with the center's written response, complete a request for the administrator to review the investigation findings.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064</p> <p>Based on observation, interview, and record review, the facility failed to justify the ongoing use of an indwelling urinary catheter for one (R11) of three reviewed.</p> <p>Findings include:</p> <p>Review of the medical record revealed R11 was admitted to the facility on [DATE] with diagnoses that included functional urinary incontinence. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/24 revealed R11 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool, did not have an indwelling catheter, was not on a urinary toileting program, and was always incontinent of urine.</p> <p>On 01/13/25 at 09:31 AM, R11 was observed sitting in their wheelchair in their room, eating breakfast. R11 reported she had an indwelling urinary catheter that was uncomfortable. R11 reported the facility inserted the catheter because the resident was sick, really sick and had pus in their bladder. R11's catheter tubing was observed with clear, yellow urine.</p> <p>Review of the Nurses Note dated 12/19/2024 revealed Resident had a large emesis this AM. [Physician E] was in the facility and ordered repeat [laboratory tests] for Diarrhea and Vomiting. Start [intravenous [IV fluids]. IV was successfully inserted .infusing without any issues .Resident was offered oral fluid and was able to drink.</p> <p>Review of a second Nurses Note dated 12/19/24 revealed This nurse called [Physician E] with lab results. [Physician E] stated continue IV fluids. [Physician E] alerted resident still appears weak but is able to coherently answer questions.</p> <p>Review of a third Nurses Note dated 12/19/24 revealed [Physician E] notified of BP [blood pressure] 140/60 and Pulse of 104. Order noted to Give Rocephin [antibiotic] 1GM IM QD x 3 days [1 gram intramuscular every day for three days]. May Insert Foley Catheter to monitor Fluid output.</p> <p>Review of the Physician's Order dated 12/19/24 revealed an order for an 18 French urinary foley catheter.</p> <p>Another Nurses Note dated 12/19/2024 revealed Upon Foley Catheter Insertion, Dark Odorous, cloudy urine obtained- 500ml [milliliters] output via Catheter. Resident tolerated Foley insertion procedure well. [Physician E] notified of Urine obtained and order noted to send it out for UA with C&S [urinalysis with culture and sensitivity] if indicated.</p> <p>Review of the Physician E's Note dated 12/19/24 revealed Basically, this patient does have:</p> <ol style="list-style-type: none"> 1. Acute toxic metabolic encephalopathy 1. Acute sepsis <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Dehydration</p> <p>3. Acute gastroenteritis with nausea vomiting and diarrhea</p> <p>The Physician's note did not mention an indwelling urinary catheter or monitoring of urine output.</p> <p>Review of the Nurses Note dated 12/20/2024 revealed [Physician E] in this shift. Ordered labs . Also when current IV @80/hr is complete, continue IV @ 40/hr x 2 more days . Resident was more alert and talkative. Meds taken this shift without problems. Taking fluids well.</p> <p>Review of Physician E's Note dated 12/20/24 revealed Basically the patient does have:</p> <ol style="list-style-type: none"> 1. acute toxic metabolic encephalopathy, improving 2. acute sepsis due to urinary tract infection, on Rocephin, improving 3. Acute pyelonephritis 3. Acute kidney failure due to dehydration 3. s/p acute gastroenteritis with nausea and vomiting and diarrhea .Symptomatically patient is improving. Mental status is improving no acute confusion anymore patient able to converse patient able to drink water. <p>The Physician's note did not mention an indwelling urinary catheter or monitoring of urine output.</p> <p>Review of the Medication Administration Record revealed R11's antibiotic ended on 12/22/24 and the IV fluids ended 12/23/24. There was no documented indication as to why R11 continued to have an indwelling urinary catheter.</p> <p>Review of the MAR and Treatment Administration Record (TAR) revealed urinary output was documented on every shift except 12/29/24 dayshift, 1/1/25 dayshift, and 1/7/25 evening shift. The medical record did not reveal any indication that R11's output was evaluated and/or discussed with the physician.</p> <p>In an interview on 01/14/25 at 09:59 AM, Unit Manager (UM) D reported R11's indwelling urinary catheter was inserted to monitor their output while on IV fluids. When asked how long the foley was indicated for, UM D reported Physician E did not indicate at the time of the order.</p> <p>In an interview on 01/14/25 at 10:08 AM, Director of Nursing (DON) B reported R11's indwelling urinary catheter was indicated to monitor urine output while receiving IV fluids. When asked why R11's urinary catheter was not removed sooner than 1/14/25, DON B reported it must have been an oversight</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 01/14/25 at 10:20 AM, Physician E reported R11 had extreme dehydration, signs of sepsis and was totally out of it. Physician E reported R11 had low urine output, was started on IV fluids and antibiotics, and therefore an indwelling catheter was inserted to monitor urine output. Physician E reported the next day (12/20/24), R11 looked a little better. When asked how long they expected R11 to have the catheter, Physician E reported about a week or so, but reported they may not have given any clear instruction.</p>		