

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER South Lyon Senior Care and Rehab Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Reynold Sweet Parkway South Lyon, MI 48178	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, homelike environment, in 12 resident rooms (Room #s 101, 106, 108, 111, 114, 115, 117, 118, 119, 120, 122, and 123), in multiple shower rooms and throughout the hallways.</p> <p>Findings include:</p> <p>On 2/18/25 between 11:00 AM - 2:00 PM, observations of the A and B halls revealed the following environmental concerns:</p> <p>room [ROOM NUMBER]-1 was observed to have damaged drywall near the right side of the bed that was heavily gouged out. The flooring of the room contained scattered wrappers.</p> <p>room [ROOM NUMBER]-2 was observed to have an overbed light that was approximately five to six inches long (unable to be reached by the resident). The flooring near and under the resident's bed had scattered debris.</p> <p>The central shower on A hall was observed to have a heavily soiled privacy curtain covered in various dark stains.</p> <p>room [ROOM NUMBER]-1 and 106-2 were observed to have soiled privacy curtains with heavy staining and the flooring was littered with scattered debris and dirt.</p> <p>room [ROOM NUMBER]-1 was observed to also have a wall next to the right side of their bed that had multiple sticker residue, scratches and the bedside dresser was observed to have the top edging of the dresser hanging down which exposed the particle board underneath (porous material and unable to be properly sanitized).</p> <p>Both residents requested to observe the toilet as there was poop on the toilet that had been there for at least a few days. The Bathroom shared by 106-1 and 106-2 was observed to have a dark fecal-like substance stuck on the inner portions of the toilet bowl. Additionally, the sink caulking was split and the elevated commode placed over the toilet was observed to have multiple areas of peeled coating with exposed rust.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER]-1 was observed to have a heavily soiled privacy curtain. The wall next to the bed was observed damaged with heavily gouged out drywall</p> <p>room [ROOM NUMBER]-2 was observed to have a privacy curtain that was soiled with stains and there was multiple scattered debris throughout the flooring of the room.</p> <p>room [ROOM NUMBER]-2 was observed to have a heavily soiled privacy curtain with dark stains.</p> <p>On 2/19/25 at 11:10 AM, additional observations of the A and B hall environment revealed:</p> <p>room [ROOM NUMBER]-1 and 106-2 were observed to continue to have soiled privacy curtains with heavy staining and the flooring was littered with scattered debris and dirt.</p> <p>room [ROOM NUMBER]-1 was observed to also have a wall next to the right side of their bed that had multiple sticker residue, scratches and the bedside dresser was observed to now have the top edging removed, but the exposed particle board edges remained.</p> <p>The bathroom shared by 106-1 and 106-2 was observed to continue to have dark brown fecal-like substance on the inner portions of the toilet bowl (as observed on 2/18/25). The sink caulking remained split and the elevated commode placed over the toilet was observed unchanged from 2/18/25.</p> <p>room [ROOM NUMBER]-1 and 108-2, the flooring in the room remained soiled with various debris and garbage under the beds and behind the toilet in the shared bathroom.</p> <p>On 2/19/25 at 11:18 AM, an interview was conducted with the Administrator. When asked about their housekeeping department, they reported Housekeeping Supervisor (Staff 'C') was in charge of that and when asked if they were fully staffed, the Administrator reported they were, seven days a week. At that time, the Administrator was requested to observe the A hall and confirmed the same findings as identified above.</p> <p>When asked about the privacy curtains, the Administrator reported they had identified several concerns with the environment when they began working at the facility in June 2024 and were also a part of their environment rounds the department heads did Mondays, Tuesdays, and Fridays. They also reported they and (Corporate Staff) did environmental rounds. When asked to provide that documentation for review, they reported they weren't sure they had to keep them but would provide a blank copy. The Administrator reported the privacy curtains were on back-order and had done an audit in November 2024 and replaced about eight. They further reported in the meantime, the facility cleaned the ones they could, but the stains might remain visible.</p> <p>The Administrator was asked about the soiled flooring and reported the floors were stripped but due to colder temperatures and stronger odors of the chemicals, they were waiting to resume the flooring until it was warmer. When asked about the scattered debris and garbage throughout the flooring, the Administrator reported that should be done daily.</p> <p>Upon observation of the bedside dresser in room [ROOM NUMBER]-1, the Administrator reported they would likely have to add that to their room rounds as dressers weren't on there but confirmed the current condition was a concern.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/19/25 at 11:30 AM, an interview was conducted with the Housekeeping Director and the Administrator. The Administrator reviewed the concerns identified during the earlier observations and the Housekeeping Director was directed by the Administrator to locate privacy curtains.</p> <p>On 2/19/25 at 11:45 AM, an interview was conducted with the Housekeeping Supervisor (Staff 'C'). At that time, when asked to observe several resident rooms, Staff 'C' confirmed the same observations of the soiled walls, flooring, and fecal matter on toilet. Staff 'C' reported their staff wasn't finished cleaning the hallways for the day, but was informed the same concerns were observed on 2/18/25 and today.</p> <p>Upon observation of the hallway behind the A hall fire door, there was a build-up of dust, debris and webbing. Staff 'C' reported they would have to follow up with their staff on what they should be cleaning.</p> <p>On 2/19/25 at 12:26 PM, the Administrator reported they did not keep the room round audits but were aware they should keep those now.</p> <p>Review of the documentation provided by the facility in regard to the privacy curtains included an initial privacy curtain quote for two cubicle curtains with [name of linen provider] and a second quote on 1/27/25 for four cubicle curtains.</p> <p>On 2/20/25 at 9:46 AM, a phone interview was conducted with an unidentified representative from the linen service provider. They were asked to confirm if there have been any concerns with delay in or back-order of privacy curtains and they reported they would follow-up. There was no return call by the end of the survey.</p> <p>Review of the privacy curtain audits provided included audits done in October 2024 and February 2025 (2/19/25 after concerns were brought to the facility's attention). The audits revealed numerous concerns labeled dirty. Some were noted as being replaced, and others had additional dates, or were marked clean but noted as replaced.</p> <p>On 2/20/25 at 12:30 PM, the Administrator was asked about the smaller-sized order for the privacy curtains (two in October and four in January) despite the larger number of soiled privacy curtains observed currently, and they reported that some were able to be replaced, but others were cleaned, but the stains remained.</p> <p>Review of the documentation provided for a request of a facility policy for clean, comfortable, homelike environment revealed there was no policy, but a copy of the regulation which read, .Environment The facility must provide (1) A safe, clean, comfortable, and homelike environment .(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior .</p> <p>34208</p> <p>On 2/18/25 at 8:55 AM, the privacy curtain between bed 118-1 and 118-2 was observed to be heavily soiled with yellow and brown stains.</p> <p>On 2/18/25 at 12:11 PM, an observation of the Burgundy [NAME] unit was conducted and revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The toilet in room [ROOM NUMBER] had fecal matter on the rim. The bathroom floor had sandpaper type strips adhered that were coming unpeeled from the tile. Underneath the soap dispenser was a large patch of unsanded, unpainted drywall mud. The drip tray for the soap dispenser had an accumulation of pinkish/brown liquid contained in it.</p> <p>The sink plumbing in room [ROOM NUMBER]'s bathroom were exposed with a build-up of dust and cobweb debris. Visitors in the room had complaints about the exposed dirty plumbing and the heavily soiled privacy curtain. They said they didn't think the curtain had been changed in a, couple of years.</p> <p>The bathroom sink plumbing in room [ROOM NUMBER] was observed with a large accumulation of dust and cobwebs on the pipes along with dust and stains on the wall adjacent to the plumbing under the sink. It was observed the bathroom had two large soap dispensers mounted to the wall, with only one containing a soap bottle. The drip tray for the soap dispenser containing soap had an accumulation of pinkish/brown liquid contained in it.</p> <p>The toilet in the bathroom of room [ROOM NUMBER] was observed with a commode placed over the bowl. It appeared the majority of the metal legs and crossbars of the commode were without the light gray paint and took on a dark red/brown rusty appearance. It was further observed a large yellow stain on the base of the white porcelain toilet where the base met the floor.</p> <p>The bathroom floor in room [ROOM NUMBER] appeared soiled with paper and rubbish debris scattered around. The white toilet bowl had light green streak stains and a faint black ring at the level of the water in the bowl.</p> <p>The wall under the sink in the bathroom of room [ROOM NUMBER] had areas of chipped paint and brown stains. In room [ROOM NUMBER], the wall along and under the sink was soiled with chipped paint and brown smears. It was observed the bathroom had two large soap dispensers mounted to the wall, with only one containing a soap bottle. The drip tray for the soap dispenser containing soap had an accumulation of pinkish/brown liquid contained in it.</p> <p>The bathroom in room [ROOM NUMBER] had two large soap dispensers mounted to the wall, with only one containing a soap bottle. The drip tray for the soap dispenser containing soap had an accumulation of pinkish/brown liquid contained in it. The toilet bowl appeared with a stain ring at the level of the water and the toilet paper dispenser was missing the front plastic cover.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275</p> <p>Based on interview and record review, the facility failed to ensure a referral was made for a level II evaluation (a comprehensive evaluation completed by the local community mental health agency) for one (R49) of one residents reviewed for PASARR (Preadmission Screening/Annual Resident Review) screenings. Findings include:</p> <p>On 2/18/24 at approximately 12:01 PM, a review of R49's clinical record revealed the resident was initially admitted into the facility on [DATE] with diagnoses that included: hemiplegia and hemiparesis (weakness/paralysis) following cerebral infarction (stroke), generalized anxiety disorder and brief psychotic disorder (according to the DSM-5/diagnostic and statistical manual of mental disorders, this diagnosis is a sudden onset of psychotic behavior that lasts less than one month - that includes at least one the following psychotic symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) . A review of the resident's Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition).</p> <p>A review of a PASARR Level I Screening form (DCH-3877) signed and dated on 1/9/24 by Social Worker (SW) E revealed R49 had diagnoses of mental illness indicated by marking 'Yes' in section II. The diagnoses included: Mood d/o (disorder) with depression, Brief Psychotic D/O, Adjustment d/o with adjustment d/o with anxiety .Rx (prescription): Celexa, Seroquel. The instructions on the form included If any answers to items 1-6 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 .</p> <p>A Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification - Level II Screening Form with instructions that read The patient screened shall require a comprehensive LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician's assistant, nurse practitioner or physician. Indicate which exemption applies . The form contained R49's name , date of birth, facility address and phone number - The Exemption Criteria was blank and no signature was noted below the document.</p> <p>On 2/19/25 at 9:25 AM, an interview was conducted with SW E . When queried about the Level II evaluation for R49 , SW 'E' reported they would look for it.</p> <p>On 2/19/25 at approximately 2:18 PM, a follow up interview was conducted with SW 'E'. SW 'E' reported a 3878-exemption form was in error as the resident did not have a dementia diagnosis. SW 'E' was not able to provide a level II evaluation.</p> <p>The facility was asked to provide their PASARR policy. A form (DCH-3877) was provided that documented, in part, the following: .This form is used to identify prospective and current nursing facility residents who meet the criteria for mental illness .who may be in need of mental health services. Section II and III must be completed .Change in Condition. This form must be completed by the nursing facility .Section II .all 6 items . must be completed .When there are more than Yes answers under Section II, complete form DCH-3878 .if referring agency is seeking to establish exemption criteria .</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>Based on observation, interview and record review, the facility failed to ensure safe positioning of a resident's bed in proximity to a wall heating unit and ensure a complete and thorough investigation into the circumstances of the incident for one (R164) of four residents reviewed for accidents.</p> <p>Findings include:</p> <p>On 2/18/25 at 11:00 AM, R164 was observed laying in bed, on a bariatric sized adaptive mattress. The resident was able to participate with small, basic discussion but was unable to provide any specific details about their situation.</p> <p>During a brief record review, a nursing progress note on 2/12/25 at 3:16 PM read, .Writer went to assess resident's finger. Yesterday, therapy observed blister to right ring fingertip. Resident is unable to communicate with staff effectively and has limited bed mobility, leans to the right in bed. Resident was lying in bed, bed <sic> at this time was against the wall which was touching the heater. Heater caused the bed frame to become hot to touch. Residents finger was touching bed frame and blister formed. Blister is closed, current treatment order to monitor and no dressings in place. MD (Physician) and family aware. Resident doesn't appear to have any pain related to blister.</p> <p>On 2/18/25 at 1:13 PM, an interview was conducted with R164's daughter who was visiting at bedside. When asked about the resident's finger burn, the daughter reported it was the resident's right ring finger and the daughter then picked up the resident's right arm to show the area. The resident's right ring finger tip was observed covered with a thick, purplish/yellow blister-like cap. Upon lifting the arm, the resident yelled out Oh that hurts. When asked how they think that occurred, the daughter reported they had no idea but did state the resident had been in a bed that was lower and might have been too close to the heat cover along the wall.</p> <p>Observation of the area along the wall of R164's current bed revealed a heating unit that ran under the window and along the wall next to the right side of the resident's bed that also had a small wood ledge above the unit.</p> <p>Review of the clinical record revealed R164 was admitted into the facility on [DATE] with diagnoses that included: other toxic encephalopathy, encounter for attention to gastrostomy, tachycardia, chronic kidney disease, morbid obesity due to excess calories, type 2 diabetes mellitus without complications, ulcerative colitis unspecified with intestinal obstruction, thyrotoxicosis, ileus, acute embolism and thrombosis of right peroneal vein, acute kidney failure, and personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits.</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], R164 had severe cognitive impairment, had communication deficits and was sometimes understood and could sometimes understands others, had upper and lower extremity impairment on both sides, and had no skin concerns.</p> <p>R164's care plans and assessments identified the resident required two person max assist with a Hoyer lift and was totally dependent upon staff for all aspects of care.</p> <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>A skin management care plan initiated on 2/5/25, revised on 2/19/25 by Clinical Corporate Nurse (Nurse 'J') documented .Blister right ring finger with two interventions added on 2/12/25. One of the interventions pertained to the blister and read, Monitor right ring finger for s/s (signs/symptoms) infection or changes in blister.</p> <p>Review of the skin and wound evaluations included an assessment dated [DATE] (one day post discovery) which documented, .Blister .Right Plantar - 4th Digit (Ring Finger), Tip .In-House Acquired .Exact Date: 2/11/2025 .Wound Measurements .Area 1.3 cm2 (square centimeter), Length 1.5 cm, Width 1.1 cm, Depth Not Applicable .Intact Blister .Wound Pain: 0 .Orders (left blank) .Treatment .Soap & Water .No dressing applied . The section for notifications had check marks next to Practitioner Notified, Resident/Responsible Party Notified and Therapy (Physical, Occupational and Speech Therapy) were noted as notified with a check mark, but there was no information documented for the prompting to enter the name of who was notified (left blank).</p> <p>Review of the eINTERACT Change in Condition Evaluation dated 2/12/25 at 2:57 PM completed by the Assistant Director of Nursing (ADON) read, .The change in condition, symptoms or signs I am calling about is/are .Skin wound or ulcer .This started on: 2/11/2025 .What time of day did this start? 1. Morning .Skin Evaluation .3. Blister .Describe the blister: 1. Secondary to any burn more than a minor one .Right ring fingertip .Pain Evaluation .Is the resident cognitively able to rate their pain scale? .2. No .(The 5 questions to evaluate the cognitively impaired resident were all None or normal) .What do you think is going on with the resident: .RN: I think the problem may be: Resident has limited mobility, is unable to tell staff when she gets hot, bed was up against the heater and frame of bed got hot, resident burned finger on bed frame .Reported to primary care clinician: [Name of Physician 'I'] .2/11/2025 2300 .Orders obtained from the clinician (blank) . Name of family/healthcare agent notified: [name of husband] .Date and time of family notification: 2/12/2025 1500. (This assessment and care plan were not documented as completed until 2/12/25, despite the incident being identified on 2/11/25. The husband was attempted to be contacted for an interview but was not available.</p> <p>Review of R164's physician notes with Attending Physician/Medical Director (Physician 'I') on</p> <p>An entry on 2/14/25 at 12:08 PM , 2/14/25 at 7:40 PM, included conflicting documentation of R164 being Alert, not oriented to time place or person .Patient 4 person hoyer lift max assit <sic> with transfers .Patient is alert oriented times 3 (person, place and time) . There was no mention of the blister or incident from 2/11/25 and the physician's section for SKIN was blank.</p> <p>Review of the physician's progress notes from 2/10/25 to 2/19/25 revealed although the documentation identified the resident was evaluated by Physician 'I' on 2/10, 2/12, and 2/14, there was no mention of R164's incident with the blister found on 2/11/25 or any skin condition (the section for SKIN had no further details - blank).</p> <p>Additionally, Physician 'Is documentation from a late entry created on 2/14/25 at 7:39 PM for 2/12/25 at 7:37 PM and another entry on 2/14/25 at 7:40 PM both revealed conflicting documentation pertaining to R164's mental status and level of assistance required with transfers which read, .ALERT, NOT ORIENTED TO TIME PLACE OR PERSON .PATIENT IS ALERT ORIENTED TIMES 3 (Person/Place/Time) .PATIENTI <sic> 4 PERSON HOYER LIFT MAX ASSIT <SIC> WITH TRANSFERS .</p> <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>There was no additional documentation provided for review such as details of the staff that identified the blister, who the staff were that provided R164 care on 2/11/25, what was done on the date it was discovered (2/11) since all documentation reflected this was completed on 2/12/25, and whether the facility had assessed similar residents, room environment/heater and bed positioning, education or interviews/statements.</p> <p>On 2/19/25 at 1:05 PM, an interview was conducted with the DON and Corporate Clinical Nurse (Nurse 'J'). When asked to review the details of R164's blister that was identified on 2/11/25, Nurse 'J' reported it was an injury of unknown origin, but because the bed was close to the wall, they had even questioned about how that occurred. The concern was the bed frame was warm that day, so we took steps to remedy. When asked about the lack of details in the facility's investigation such as who found it, when staff had last checked on the resident, etc, both the DON and Nurse 'J' confirmed those details were not included in the report. Nurse 'J' reported they would have to continue to work on educating the ADON as they were new to that role and not familiar with long-term care requirements.</p> <p>When asked why the documentation wasn't initiated until the following day, Nurse 'J' reported they weren't sure but thought it had started on 2/11/25. When asked about the lack of physician assessment following the incident, despite the documented visits on 2/12 and 2/14, Nurse 'J' reported they had identified that concern as well when they were reviewing the documentation.</p> <p>When asked about the lack of staff interviews to determine when the resident was last checked, or obtain other pertinent details, the DON reported the hallway R164 resided on doesn't have specific room assignments and the nursing assistants do all the rooms.</p> <p>When asked about what was implemented following the incident, the DON reported they immediately moved the resident to the bed by the door. However this was not reflected on the resident's census information as completed until 2/12/25. When asked about the dates, both the DON and Nurse 'J' reported they weren't sure and Nurse 'J' reported that had something to do with the business office and the billing system.</p> <p>At 1:21 PM, the ADON entered the room and was asked about what they could recall about the events on 2/11/25. The ADON reported they were notified on 2/11 and they moved the resident from bed 2 to bed 1 and the next day we got the bariatric air mattress ordered and couldn't set it up so they moved bed 1 back to bed 2 and (name of Maintenance Director) put breaks on so it (the bed) wouldn't be against the heater. When asked about their documentation that shows it was initiated on 2/12, not on 2/11, the ADON was unable to offer any further explanation.</p> <p>At that time, the DON and Nurse 'J' were asked about the lack of Physician documentation to address the blister, as well as the discrepancies in the physician assessment regarding the mental status and transfer status and Nurse 'J' acknowledged the concern and further reported they had previously had discussion with Physician 'I' about their documentation. They were informed of the request to speak to Physician 'I' who was currently out of the country.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER South Lyon Senior Care and Rehab Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Reynold Sweet Parkway South Lyon, MI 48178	

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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>On 2/20/25 at 8:37 AM, a phone interview was conducted with Physician 'I'. When asked about their lack of documentation for R164's blister (change of condition) and when they were notified, they reported they were notified when it was seen by nursing (unable to identify exact date) and they saw the resident on Friday (2/14/25). When asked why their documentation didn't reflect any evaluation or mention of the blister, Physician 'I' reported they forgot to include that but reported they did see R164 on Friday. When asked who had notified them of the blister initially, they reported it was [Name of ADON] who called me.</p> <p>When asked about their progress note they added to the clinical record this morning at 5:39 AM which read, Patient was seen and examined on 2/14/25 Noticed by patients nurse on 2/12/25 a new blister on the Right ring finger. Patient is not a good historian as per the staff patients finger may have touched the heater on the wall next to her bed. Patient denied pain. O/E (On examination) there is single intact blister on the pad of the right middle finger Orders given to inform MD for increased pain erythema pain or drainage from the blister site., Physician 'I' reported they missed documenting that and once they were informed (after it was identified as a concern during survey) they added this documentation.</p> <p>When asked about their conflicting documentation in their assessments for them being notified on 2/12/25 when it had been identified on 2/11/25, as well as the resident being alert and oriented x 3 and then not oriented to person, place, and time, and requiring 4 person assist with hooyer when it was only two, Physician 'I' did not respond about the conflicting dates and reported that was an error and the resident's cognition does fluctuate and they only required two person assist with hooyer lift.</p> <p>When asked if they copy and pasted their notes from previous visits, how did they ensure their documentation was accurate to reflect current status, Dr. T reported they sometimes did (copy and paste) but if it's an incident they usually do put a note in, like for a fall or wound.</p> <p>On 2/20/25 at 9:20 AM, an interview was conducted with the Therapy Manager (Staff 'G') who confirmed they were the therapist that identified R164's fingertip blister. When asked to explain the events of when it was first seen, Staff 'G' reported when R164 was working with them in the gym, they were working on their core and there was three therapists working with the resident and they put the resident's hands on the bars to lean forward, and that's when Staff 'G' noticed the resident's finger looked different. When asked what happened following that, Staff 'G' reported they went straight to (name of Administrator and DON) and told them Hey I think this was from the bed. When asked if they happened to see the bed on 2/11/25, Staff 'G' reported they had and it was warm. They further reported that although there was a piece of wood on top and along the wall, the bed was lower and got very hot and R164 can't verbalize to you.</p> <p>Staff 'G' reported the resident's stoke prevented them from feeling pain and was unable to tell them if they were in pain. They reported often during treatment, when they say the resident was difficult to determine if in pain, they meant the resident can't verbalize their pain level and what they need.</p> <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>When asked about the observation during the interview with R164's daughter and the resident verbalizing Oh that hurt, Staff 'G' reported R164 will do that with any limb that you move, they are unable to tell you where the pain is, think it's their sensory reception. Staff 'G' further reported In their professional opinion, they were not sure if it's actual pain or not, since when they did active and passive range of motion, it's the same movement and response.</p> <p>When asked what they could recall was done following the incident being reported, Staff 'G' reported the resident was moved to the other side of the room but needed an extended air mattress and was given a new bed which was currently in place. When asked if anyone had asked them to provide documentation of their account of the incident, they reported they were not.</p> <p>On 2/20/25 at 12:30 PM, an interview was conducted with the Administrator. They were informed of the concern with the incident that occurred and lack of thorough investigation, including conflicting times/dates documentation was completed by both nursing staff and Physician I' and they acknowledged the concerns.</p> <p>According to the facility's policy titled, Accidents and Incidents - Investigating and Reporting dated December 2011:</p> <p>.The following data, as applicable, shall be included on the Report of Incident/Accident form .The circumstances surrounding the accident or incident .The name(s) of witnesses and their accounts of the accident or incident .The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions .The date/time the injured person's family was notified and by whom .Any corrective action taken .Follow-up information .Other pertinent data as necessary or required .</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>34208</p> <p>Based on observation, interview, and record review the facility failed to ensure a medication error rate less than five percent when two medication errors were observed from a total of 29 opportunities for two residents (R#'s 20 and 52) of four residents observed during medication administration, resulting in a medication error rate of 6.9%. Findings include:</p> <p>On 2/18/25 at 9:07 AM, Nurse 'B' was observed preparing medications for administration to R20. Upon completion of the preparation, Nurse 'B' administered the medications including one nasal spray (ipratropium) for the treatment of a runny nose associated with allergies or the common cold. At the end of the observation, Nurse 'B' confirmed all medications due at that time were given.</p> <p>On 2/20/25 at 9:41 AM, the medications administered to R20 were compared against their physician's orders and Medication Administration Record (MAR). At that time, it was discovered R20 had a second nasal spray (fluticasone propionate) for the treatment of allergies to be administered with their morning medications that was not observed as administered on 2/18/25, but had been signed out as given.</p> <p>On 2/19/25 at 8:18 AM, Nurse 'K' was observed preparing medications for R52. Nurse 'K' prepared multiple medications including a fluticasone propionate nasal spray. Nurse 'K' entered the room and gave R52 the bottle of nasal spray. Nurse 'K' did not instruct R52 how many sprays to administer into each nostril and R52 was observed to nasally inhale three sprays in their left nostril and two sprays in their right nostril.</p> <p>On 2/20/25 at 9:50 AM, R52's physician's orders and MAR were reviewed and revealed the instructions for the propionate nasal spray were to nasally inhale one spray in each nostril.</p> <p>On 2/20/25 at 11:05 AM, an interview was conducted with the facility's Director of Nursing (DON). They were made aware of the omitted medication for R20 and acknowledge the concern. They were then asked if R52 should have been instructed on the use of the nasal spray and said they should have been.</p> <p>A review of a facility provided policy titled, Administering Medications was reviewed and read, Medications shall be administered in a safe and timely manner, and as prescribed .</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208</p> <p>Based on observation, interview, and record review, the facility failed to ensure the consistent use of assistive devices for eating for one resident (R59) of seven residents reviewed for dining. Findings include:</p> <p>On 2/18/25 at 8:57 AM, R59 was observed in their bed eating breakfast. R59 was non-verbal but appeared to appropriately answer simple yes/no questions by nodding/shaking their head. A review of their meal ticket indicated all cups should contain lids and a maroon mug with a lid was used for hot liquids. R59's tray contained a cup of juice and a cup of chocolate shake supplement without lids or straws.</p> <p>On 2/18/25 at 12:47 PM, R59 was in their room with a lunch tray that contained a bowl of tomato soup. Certified Nurse Aide (CNA) 'L' was in the room and poured the soup into a coffee mug with no lid, saying it was easier for R59 to consume. The cup was not observed to be the maroon cup with a lid as indicated on their meal ticket. It was further observed a glass of apple juice and a cup of chocolate shake supplement were provided with the tray but did not have lids on them.</p> <p>On 2/19/25 at 11:13 AM, a review of R59's Dietary Profile assessment dated [DATE] was conducted and read, .Lidded Cups with Straw; Maroon Mug with Lid. Divided Plate .</p> <p>On 2/20/25 at 9:18 AM, an interview was conducted with Speech Language Pathologist/Therapy Manager 'G'. They were asked about the recommendations for R59 to have lidded cups with straws and lidded mugs and said it was to prevent spillage of the drinks, promote safety with hot liquids, and to slow down the rate of intake to prevent aspiration. They further indicated all cold drinks should have lids and straws and hot liquids should be in the burgundy mug with a handle an lid with the small opening for drinking.</p> <p>A request for a policy on adaptive dining equipment was made and not provided, however the Administrator e-mailed the following on 2/20/25 at 10:56 AM, .we do not have an adaptive equipment for dining policy. Therapy evaluates residents upon admission and works with nursing and dietary staff to communicate resident needs.</p>		