STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235067	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Shiawassee County Med Care Fac	275 Caledonia Drive Owosso, MI 48867

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 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** 32064 This citation pertains to Intake MI00143380. Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for two (Resident #20 and Resident #23) of six reviewed. Findings include: Resident #20 (R20) Review of the medical record revealed R20 admitted to the facility on [DATE] and was readmitted from the hospital on 3/4/24 and again on 3/13/24 with diagnoses that included humerus fractures of the right and left arm, dementia, pressure ulcer of the sacral region, pressure induced deep tissue damage of left heel, stage 2pressure ulcer of right heel, stage 2 pressure ulcer of left buttock, and stage 2 pressure ulcer of right buttock. Review of the Wound-Weekly Observation Tool dated 3/7/24 revealed R20 had a suspected deep tissue injury to her left heel. Special equipment included motorized air mattress, air cushion, and boots. The current treatment plan included skin prep . R20 was hospitalized from 3/7/24 until readmission to the facility on [DATE]. A Physician's Order dated 3/14/24 revealed an order for skin prep to both heels twice daily. This order was entered as a therapy order and therefore not transcribed onto the Treatment Administration Record (TAR) or Medication Administration Record (MAR). The treatment was not documented as completed twice daily. Review of R20's care plans failed to reveal any mention of an actual pressure injury skin impairment, boots, heels up device, or skin prep treatments. On 3/20/24 at 9:45 AM, R20 was observed in bed. R20 had both her heels floated off the bed on a heels up device. R20 had a visible suspected deep tissue injury to her left heel. The right heel was not able to be visualized. R20 did not have boots on her feet. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235067	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Shiawassee County Med Care Fac	275 Caledonia Drive Owosso, MI 48867

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/22/24 at 8:55 AM, R20 was observed lying in bed. R20's heels were not floated off the mattress nor did R20 have boots in place. R20's heels were resting on the bed. The heels up device was against the wall and the boots were on the floor near the wall. In an interview on 3/22/24 at 9:33 AM, Registered Nurse (RN) E reported the only treatment R20 received was the dressing to her buttocks. In an interview on 3/22/24 at 10:58 AM, RN G reported R20 readmitted to the facility with pressure injuries to the right buttock, left buttock, right heel, and left heel. RN G reported the skin prep order on 3/14/24 was not entered on the MAR or TAR and therefore there was not any documentation that the treatment had been performed twice daily. RN G reported the heels up device or boots should also be on R20's care plan. 45038 Resident #23 (R23) Review of the medical record revealed R23 was admitted to the facility on [DATE] with diagnoses that included Respiratory Syncytial Virus (RSV), urinary tract infection, pneumonia, type 2 diabetes, and chronic obstructive pulmonary disease (COPD). During observation on 03/22/2024 at 10:33 a.m. R23's room door was closed. A sign was observed to be located beside R23's room door, which demonstrated he was on droplet precautions. Isolation cart was observed under the droplet precaution sign. Review of R23's medical record revealed a plan of care which stated, The resident has a Respiratory Infection RSV bronchiolitis. The plan of care did not demonstrate that R23 was in droplet precautions/isolation. R23's medical record also revealed a physician order Cefdinir Oral Capsule 300 mg (Milligrams), Give 1 capsule by mouth in the morning for RSV for 5 Days and give 1 capsule by mouth in the evening for RVS for 5 Days written 03/18/24. The same order had an end date of 03/24/2024. In an interview on 03/22/2024 at 10:46 Registered Nurse (RN) C explained that R23 was on droplet precautions/isolation because he had been admitted with Respiratory Syncytial Virus (RSV). She explained that he would be on those precautions/isolation until his antibiotic medication is finished. In an interview on 03/22/2024 at 11:45 a.m. Assistant Director of Nursing (ADON)/ Infection Preventionist (IP) D explained that it is her expectation that when a resident is placed on droplet precautions/isolation that the resident plan of care be updated to include what type of precautions/isolation are to be followed, which would demonstrate when it was initiated and when it could be discontinued. ADON/IP D reviewed R23's plan of care and confirmed that information regarding him being place on droplet precautions/isolation was not present in his plan of care. ADON/IP D could not explain why R23's plan of care did not include the expected information.