STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235123	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Durand Senior Care and Rehab Center, L L C	8750 E Monroe Rd Durand, MI 48429

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview and record review the facility failed to maintain dignity for 4 residents (Resident #'s 393, R24, and R13 and one unknown resident) the during the initial dining observation in the 500 hall dining room, using the reasonable person standard this deficient practice resulted in decreased self worth and loss of dignity. Findings include: Resident 393 (R393) According to the clinical record, Including the Minimum Data Set (MDS) dated [DATE] Resident # 393 (R393) was a [AGE] year old female admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, anxiety and respiratory failure. Resident # 393 scored 8 out 15 on the Brief Interview for Mental Status (BIMS) , the MDS further reflected R393 had adequate hearing and clear speech. Resident 24 (R24) According to the clinical record, including the MDS dated [DATE], reflected R24 was an [AGE] year old female admitted with a diagnosis of dementia on 12/31/14. R24 scored 00 on the BIMS (severe cognitive impairment) on the MDS dated [DATE]. Resident 13 (Resident 13) Review of the clinical record, including the MDS dated [DATE]. Resident 13 (R13) was admitted on [DATE] scored 00 (severe impairment) on the BIMS from the 04/03/24 MDS. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/24 at 12:27 PM during the 500 hall dining observation, Registered Nurse/ Clinical Care Coordinator (RN/CCC) E , Life Enrichment Director (LED) U were observed feeding residents #13 and R#24, R393 was sitting in-between them, an unknown staff person from the therapy department was initially assisting the unknown resident at the table. RN/CCC E and LED U carried on personal conversations while mechanically feeding the perspective residents, there was no attempt to engage any of the residents in conversation, there was no addressing the residents, i.e.: how are you today? or are you hungry? Would you like a drink? What would you like a bite of next? etc . instead there was a 21 minute observation of RN/CCC E and LED U discussing RN/CCC 's upcoming trip to Colorado, the number of their remaining balance of their vacation time, the fact that RN/CCC E was a vegetarian in college, what kind of macaroni and cheese they liked powder versus liquid cheese packet, how good the local fast food restaurants Jamocha shakes were, what they fed there kids for breakfast, of note it was cinnamon toast and RN/CCC E had scooby fruit snacks, what was planted in their gardens, floating down the Ausable river, their camper, their kayak and on and on. After 19 minutes of constant conversation between the two staff persons there was not one attempt made to include any of the residents at the table. With the exclusion of one interaction when RN/CCC E asked R13 if she wanted desert. After 21 minutes LED U announced to RN/CCC E that she had paper work to attend to and would get someone to cover to finish feeding R24. During this same observation Minimum Data Set Nurse (MDS Nurse) Q was assisting passing trays, she stood in the middle of the 500 hall dining room and yelling out to staff Ok, which one is [name redacted] Which one is [name redacted]. 05/10/24 08:39 AM during an interview with Nursing Home Administrator A was made aware of the direct observations that were made.

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(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** 46955 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for 2 (Resident #7 and Resident #10) of 20 residents reviewed resulting in the potential for unmet care needs. Findings include: Resident #7 (R7) Review of the medical record revealed that Resident #7 (R7) was admitted to facility 4/7/22 with diagnoses including chronic kidney disease stage 3, hypertension, bilateral carotid artery stenosis, and polyneuropathy. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/1/24 revealed that R7 had a Brief Interview for Mental Status (BIMS-a cognitive screening tool) score of 13 (cognitively intact). Review of an Annual MDS dated [DATE] revealed that R7 required set up assist with dressing including placing/removing TED hose (thromboembolic deterrent hose-specially designed stockings to help prevent blood clots and swelling in legs). In an observation and interview on 5/07/24 at 10:35 AM, R7 was observed lying in bed, on back, with head of bed positioned at an approximate 90-degree angle. R7's legs and feet were observed to be bare with mild swelling noted to both ankles and feet. R7 stated that she had issues with circulation in her legs, off and on swelling in her feet, and that she had special elastic stocking that she was supposed to wear that helped with both but stated, I couldn't really tell you the last time I've worn those. R7 stated that she was unable to put the stocking on herself, struggled to take them off, and that the staff never really offered to help her put them on. Two pair of white, knee-high TED hose observed to be hanging on the bar of R7's front wheeled walker which was positioned against the wall between her dresser and closet. In an observation and interview on 5/07/24 at 12:05 PM, R7 was observed to be self-propelling wheelchair out of her room with nonskid slippers noted on bare feet. R7 denied that staff had approached her to offer or assist with placement of TED hose yet that day. Two pair of white, knee-high TED hose observed to remain hanging on R7's front wheeled walker positioned in the same location in her room. In an observation and interview on 05/08/24 at 1:44 PM, R7 was observed sitting in wheelchair, in room, watching television. R7 was observed to have non-skid slippers on bare feet. R7 stated that she didn't have her elastic stockings on as reiterated that she was unable to put them on herself and that staff had not offered or assisted with placement yet that date. Two pair of white, knee-high TED hose observed to remain hanging on R7's walker positioned in the same location in her room as on 5/07/24. R7's Physician Order dated 12/1/23 stated, Bilateral knee high ted hose to be place [sic] on in the AM (morning) and removed at HS (bedtime). R7's corresponding Treatment Administration Record (TAR) dated 5/1/24-5/31/24 was noted to reflect same order with order signed out as administered on both 5/7/24 and 5/8/24 although not observed to be in place on either date. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Cardiac Care Plan Focus included an intervention which stated, Bilateral knee high ted hose to be placed on in the AM and removed at HS with a 7/11/22 date of initiation. R7's Kardex section titled Individual Instructions/Preferences stated, Bilateral knee high ted hose to be placed on in the AM and removed at HS. Review of R7's Progress Notes and Resident/Family Education Records for 5/7/24 and 5/8/24 was not noted to include any indication of TED hose refusal. In an interview on 5/08/24 at 2:26 PM, Certified Nurse Aide (CNA) C confirmed familiarity with R7 and was her assigned aide that date. CNA C stated that R7 was fairly independent with transfers, toileting, and dressing and used a wheelchair as her main mode of mobility. CNA C further stated that he believed R7 wore TED hose, didn't know how much help she needed to put them on as denied ever having helped her place them before, but believed that she had them on that date. Per CNA C, the assigned nurse tracked the residents that wore TED hose, would alert him of need to place, and assumed she had them on as the nurse had not told him otherwise. CNA C stated that he did not believe TED hose were reflected on the resident Kardex (tool used by the CNA to guide them as to the care needs of a specific resident) as the assigned nurse just informed him of those residents that needed to have them placed. In an interview on 5/08/24 at 2:23 PM, Registered Nurse (RN) D stated that each resident with TED hose had a specific physician order, the assigned nurse was responsible for placement, and that the TAR would be signed out to reflect placement as well as any refusal. RN D confirmed familiarity with R7 and was her assigned nurse that date. Per RN D, R7 was alert, oriented, and able to make all needs known, wore TED hose due to circulatory issues, and although was independent with most dressing required assistance with TED hose placement as was not able to physically get them on herself. RN D further stated that R7's TED hose had been placed that morning, she believed by Registered Nurse/Clinical Care Coordinator (RN/CCC) E, and therefore she had signed out the treatment as completed although had not verified that R7 actually had the TED hose in place. Upon observing R7 in the dining room participating in an activity, RN D stated that R7 did not actually have TED hose in place as she had thought and that she would be assisting her with placement upon completion of the activity. In an interview on 5/08/24 at 2:39 PM, RN/CCC E stated that TED hose was generally a physician order, applied by the assigned nurse, and signed out on the treatment sheet. RN/CCC E confirmed familiarity with R7, stated that she tended to transfer, toilet, and dress herself independently although assist of one was recommended for safety and upon referencing R7's medical record confirmed that she had an order for TED hose placement in the morning with removal at bedtime. RN/CCC E denied that she had ever assisted R7 with the placement of her TED hose, denied that she had interacted with R7's assigned nurse that date regarding her TED hose placement, and that she would be following up for there placement. In a follow-up interview on 5/9/24 at 8:53 AM, RN/CCC E stated that as confusion was present amongst staff over whose responsibility it was for the placement of physician ordered TED hose, facility wide education had been initiated as stated it was the primary responsibility of the CNA to place, per Kardex indication, and for the nurse to verify placement through order signed out on the TAR. 38383 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10 (R10): Review of the medical record reflected R10 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included diabetes, end stage renal disease and dependence on renal dialysis. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/28/24, reflected R10 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 05/10/24 at 08:38 AM, R10 was observed lying on his left side, in bed. R10 reported he went to dialysis on Monday's, Wednesday's and Friday's. He stated he returned from dialysis with a bandage to his access site, which he reported was in his left upper arm. On 05/09/24 at 01:30 PM, review of R10's medical record, including Physician's Orders and Care Plans, did not reflect care restrictions for his left arm. According to the University of Michigan, Vascular Access for Hemodialysis: What You Need to Know .What are hemodialysis and vascular access? Hemodialysis uses a dialysis machine to remove poison and extra fluid from your blood when your kidneys cannot do it (kidney failure). In order to access your blood for hemodialysis, you must have surgery to reach your blood. Vascular access is a surgical procedure that connects your artery directly to your own vein (fistula) or your artery to your vein with an artificial tube (graft). Vascular access makes lifesaving hemodialysis treatments possible .Do I have any restrictions on my access arm? . Do not let anyone take your blood pressure, start an intravenous line (IV) or draw blood from your access arm . (https://www.med.umich.edu/1libr/Surgery/VascularSurgery/HemodialysisAccess.pdf) During an interview on 05/10/24 at 09:21 AM, Certified Nurse Aide (CNA) T stated she believed R10's dialysis access port was in his left arm, so staff would not obtain blood pressures from that arm. If she was unsure, she would check the Kardex (CNA care guide) and ask the nurse. CNA T reviewed R10's Kardex and confirmed that she did not see documentation pertaining to not obtaining blood pressure on his left arm. During an interview on 05/10/24 at 09:26 AM, CNA L reported staff did not do vital signs or obtain blood pressures on the side (arm) that had a (dialysis) port. CNA L was unsure which side/arm R10's dialysis access site was on. He stated the nurse usually obtained R10's vital signs. On 05/10/24 at 09:35 AM, Registered Nurse (RN) I reported R10's dialysis port was located in his left arm, so staff would not obtain blood pressures on his left arm.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to ensure antibiotic treatment for Methicillin-resistant Staphylococcus aureus (MRSA/type of bacterial infection that is resistant to many antibiotics) was started timely for one (Resident #6) of one reviewed. Findings include: Review of the medical record reflected Resident #6 (R6) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included schizophrenia and MRSA (as of 4/29/24). The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/15/24, reflected R6 scored zero out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 05/09/24 at 10:18 AM, R6 was observed lying on his right side, in bed, as two Certified Nurse Aides (CNAs) prepared to enter his room. On 05/09/24 at 10:23 AM, R6 was observed seated in a high-back wheelchair, with a mechanical lift sling beneath him. He was observed to self-propel his wheelchair in the hallway. A Nurse Practitioner Progress Note for 4/23/24 reflected R6 had a large abscess on his left inner thigh. According to the Note, a wound culture (test to identify type of bacteria in a wound) was collected and sent to the laboratory. R6's medical record reflected an aerobic wound culture was collected on 4/23/24 and was received by the laboratory the same day. The laboratory report reflected the final results were reported on 4/27/24 and were timestamped for 2:36 PM. The culture results revealed heavy growth of MRSA and included sensitivity results (test that identifies antibiotic treatment options). R6's Physician Orders reflected Doxycycline Hyclate (antibiotic) 100 milligrams by mouth every 12 hours, for MRSA, for 14 days, was prescribed with a start date of 4/29/24 and a stop date of 5/13/24. R6's May 2024 Medication Administration Record (MAR) reflected Doxycycline administration times were scheduled for 9:00 AM and 9:00 PM. The first dose was signed out as being administered for a 9:00 PM scheduled dose on 4/29/24, which was two days after the final wound culture and sensitivity results were reported. During an interview on 05/09/24 at 10:32 AM, Registered Nurse (RN) G reported laboratory reports were entered into the electronic medical record (EMR) by the laboratory and were provided to the physician. Nurses did not receive an alert that results were available for review but were made aware through nurse shift report if laboratory test results were pending. Laboratory reports were printed out and placed in the physician's book, according to RN G. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/24 at 10:38 AM, RN/Infection Preventionist (IP) M reported laboratory results were received through the Results tab of the EMR. She stated nurses did not receive an alert that results were available for review but were good at reporting off (nurse shift report) when results were pending. IP M acknowledged that R6's wound culture was collected on 4/23/24, and results were received/reported on 4/27/24. She stated R6 started antibiotic treatment for MRSA on 4/29/24. IP M reported there were not any Nursing or Provider Progress Notes referencing why antibiotic treatment was not started on 4/27/24. She reported her expectation was that the on-call provider would have at least been notified of the results. She stated many facility providers preferred to be called personally.