| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>27446<br><br>This citation pertains to intake number MI00142697.<br><br>Based on interview and record review the facility failed to ensure one out of three residents (Resident #2) was free from abuse.<br><br>Findings Included:<br><br>In an interview on 3/12/2024 at 11:00 AM, Resident #2 (R2) stated that one time when she was being straight cathed (tube inserted into the bladder to drain urine then removed) and was exposed with her legs open in her bed, and upon a nurse leaving her room curtain and door were left open exposing her uncovered private area to anyone outside of her room. R2 said another nurse was holding her labia (flaps of skin on either side of the vagina) open during this time so she was not covered up. During the interview R2 began to cry and stated that she was humiliated, vulnerable, upset, scared, and felt threatened. R2 also stated that Registered Nurse (RN) O told her that she should have stayed home and had home care, and she was not to question her because she was the professional. R2 said that RN O told her there were no straight cath kits available so they would have to use her supply, and if she would not let them use hers she would send her to the emergency room to be straight cathed. R2 said N O was going through her closet and personal things without her permission looking for a straight cath kit.<br><br>In an interview on 3/13/2024 at 2:15 PM, Administrator A stated that on 3/1/2024 RN O refused to perform a straight catheterization procedure on R2. Administrator A stated that was when she terminated RN O's employment at the facility due to refusal to provide necessary care and services to a resident, and a time prior RN O was verbally abusive to R2.<br><br>Review of an EMPLOYEE MEMORANDUM revealed, .(RN O) was the acting supervisor in the building as the RN charge nurse. She refused to provide care to a resident and directed her subordinates not to provide care. The memorandum revealed RN O was discharge from her employment at the facility on 3/6/2024 as a result. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446<br><br>This citation pertains to intake numbers MI00142630 and MI00142697.<br><br>Based on observation, interview, and record review the facility failed to develop a comprehensive pressure ulcer care plan for two of three residents (Resident #1 & 2).<br><br>Findings Included:<br><br>Resident #1 (R1)<br><br>Per the facility face sheet R1 was admitted to the facility on [DATE]. Diagnoses include right above the knee amputation and paraplegia.<br><br>Review of a vascular (vein/artery system) Physician's (Patient Discharge Summary revealed R1 was admitted from the facility to the hospital 12/27/2024 for a right above the knee amputation. The summary revealed under discharge orders Additional Transfer Instructions, Wound site(s): left heel<br><br>-Cleans wound with mild soap and water/saline, rinse well, pat dry<br><br>-Apply Calcium Alginate to wound. (Cut to size.)<br><br>-Cover with a mepilex border.<br><br>-Change every other day<br><br>Record review of a Vascular Surgery Office Note dated 2/7/2024, revealed .Patient (R1) states he has not had any wound care offered to his left heel since being admitted (to the facility) ., and Patient will require serial debridements of left heel wound, will refer to wound care team at (name of facility) . The note also revealed, Patient may follow up as needed for heel debridements.<br><br>In an interview on 3/12/2024 at 9:10 AM, R1 stated that he had a pressure ulcer on his left heel. R1 stated that he did his own dressing changes, because no staff member had ever performed a dressing change on his left heel. R1 removed the dressing for observation. The observation of the wound revealed a pressure ulcer with full skin loss, approximately 6-7cm (centimeters) wide, 7 cm in width, and 0.2 cm in depth.<br><br>Review of R1's Minimum Data Set (MDS) assessment dated [DATE] revealed R1's left heel pressure ulcer was not documented on the assessment.<br><br>Review of R1's care plans revealed no care plan in place regarding R1's left heel pressure ulcer.<br><br>In an interview on 3/13/2024 at 1:39 PM, Registered Nurse (RN) I, who was the MDS nurse, stated that R1's left heel pressure ulcer was not documentation on his MDS assessment, because it was never documented on R1's skin assessments so she was not aware of the pressure ulcer.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 3/14/2024 at 9:22 AM, RN J, who was the wound care nurse stated that when R1 had returned from his 2/9/2024 vascular surgeon office visit she asked him for the paperwork, but said R1 refused to give the paperwork to her, and said R1 told her no treatments were needed for his left heel pressure ulcer. RN J said she did not look at R1's left heel because he had a shoe on. RN J stated she made no effort to contact the vascular surgeon's office for follow up order, stated the vascular surgeon did not tell her that he was referring R1 to the facility wound care team.<br><br>Resident #2 (R2)<br><br>Per the facility face sheet R2 was admitted to the facility on [DATE] with a diagnosis of Quadriplegia.<br><br>In an interview on 3/12/2024 at 11:00 AM, R2 R2 stated that she had a pressure ulcer on her right buttocks, DON B and RN K were aware if it.<br><br>Review of R2's skin assessments dated 2/26/2024 revealed, .excoriation (damage or removed part of the surface of the skin) noted to bilateral (both sides) buttocks, light pink and blanchable (turns white with pressure then back to pink with relief of the pressure), barrier cream applied<br><br>Review of a skin assessment dated [DATE], revealed .small scab noted to right buttocks, skin is light pink and blanchable, barrier cream applied<br><br>Another skin assess dated 3/10/2024 revealed, .small scab noted to right buttocks, skin is light pink and blanchable, barrier cream applied<br><br>In an observation on 3/12/2024 at 12:00 PM, R2 was observed to have a pressure wound to her right buttocks.<br><br>Record review of R2's active care plans revealed no care plan in place regarding R2's pressure wound to her buttocks.<br><br>In an interview on 3/13/2024 at 9:55 AM. R2 said it wasn't until 3/12/2024 that she saw NP K, and was able to tell NP K about her wound on her buttocks. R2 said NP K told her that she was never made aware of her pressure wound. R2 said no nurse had ever performed a full skin assessment on her.<br><br>In an interview on 3/14/2024 11:15 AM, DON B said that it was facility policy and her expectation that the CNA's perform a skin sweep during resident showers, and make nursing aware of any concerns.<br><br>Review of the facility's policy and procedure titled, PRESSURE ULCER PREVENTION AND CARE dated 6/2019 and revised on 2/2024, revealed under Procedure: 1. Nurses will complete the Skin Body Assessment Observation upon admission/readmission, then weekly as needed 5. Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46955<br><br>This citation pertains to intake Numbers MI00142729 and MI00142697<br><br>Based on observation, interview, and record review, the facility failed to 1) write a physician order for a laboratory (lab) test and document a resident assessment, rationale for lab test, and completion of the lab draw procedure for one resident (Resident #4) and 2) failed to administer medications as ordered by the physician, and maintain infection control prevention during catheterization for one resident (Resident #2) of 5 reviewed, resulting in residents not receiving care and treatment in accordance with professional practice and the potential for worsening medical conditions.<br><br>Findings include:<br><br>Resident #4<br><br>Review of the medical record revealed that Resident #4 (R4) was admitted to facility 12/15/23 with diagnoses including stage 4 pressure ulcer of right upper back, pressure-induced deep tissue damage of unspecified site, quadriplegia, contracture of right/left upper arm, moderate protein-calorie malnutrition, adult failure to thrive, and degenerative disease of nervous system. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/21/23 reflected a staff assessment for mental status indicating that R4 had severely impaired cognitive skills for decision making. Section GG of the MDS indicated that R4 was dependent for oral hygiene, toileting, showering, dressing, personal hygiene, bed mobility, and transfers. Section M of the same MDS reflected that R4 was admitted with unhealed pressure injuries.<br><br>In an observation on 3/13/24 at 9:46 AM, R4 was observed lying in bed positioned toward left side with positioning wedge at right upper back region. R4's bilateral upper extremities noted to be flexed inward at elbows and bilateral lower extremities flexed at knees. R4 was observed to have eyes open, smiled when name called, and shake head in response to yes or no questions but provided no verbal response.<br><br>Review of R4's electronic medical record (EMR) completed with the following findings noted:<br><br>Progress note dated 2/23/24 at 11:06 AM stated, Lab work received this am [morning] and reviewed by nursing staff. Some nutritional deficits noted. Labs sent over to [name of R4's physician] for review . Further review of R4's medical record revealed no physician or nursing progress note in days prior to the 2/23/24 note to reflect a resident assessment, rationale for lab draw, or completion of the lab draw procedure. Review of R4's physician orders was not noted to include an order for a lab draw although a lab report within the Resident Documents section of R4's EMR included a lab report for R4 dated 2/21/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 3/14/24 at 8:59 AM, Director of Nursing (DON) B stated that when a lab order was received from the physician, a corresponding order for the lab test would be written within the EMR, the lab order would then be entered into the lab system for a routine draw on a Tuesday when the phlebotomist from the lab would draw blood at the facility. DON B further stated that when a lab was ordered to be drawn on any day but a Tuesday, that a Registered Nurse at the facility would draw the blood and that the blood sample would then be transported to the local hospital lab to be ran.<br><br>DON B confirmed familiarity with R4, stated that R4 had recently had a change in condition including intermittent diaphoresis (sweating) as well as increased anxiety and muscle tensing that was thought to potentially be correlated with pain, that she had reviewed R4's status directly with the physician, and received a verbal order from R4's physician for lab tests to rule out a medical cause for R4's symptoms prior to a potential pain medication adjustment. Per DON B, upon receipt of the verbal physician order for the lab test, she proceeded to draw R4's blood herself that same day but never wrote an order in R4's EMR for the lab draw nor did she complete a progress note to reflect R4's status, coordination with the physician, or completion of the lab draw procedure. DON B further stated that when an acute change in resident status was noted, she would expect to see a corresponding nurses note to reflect resident status and physician coordination and that whenever the facility staff drew a residents blood, she would expect to see a nurses note completed to reflect rationale for the blood draw, the blood draw procedure itself including body location of draw, type of needle used, and resident tolerance to the procedure. DON B stated that she would be completing a late nurses note to reflect R4's assessment, physician coordination, and the blood draw procedure that she had completed at the time R4's change in condition was noted.<br><br>Review of the facility policy titled, Standards of Nursing Practices with a reviewed date of 1/2024 stated, Procedures .Responsibility with Medications and Physicians Orders .1. The licensed nurse that receives an order and notes the order is responsible to carry the order through by placing in achieve Matrix [the facility's EMR] .Physical assessment and change of condition .1. Residents having any change in condition will have a complete nursing assessment performed and documented .<br><br>Review of the facility policy titled, Laboratory Test with a reviewed date of 1/2024 stated, Procedure: 1) The Licensed nurse receiving the order for any Laboratory test will transcribe the order .<br><br>27446<br><br>Resident #2 (R2)<br><br>Per the facility face sheet R2 was admitted to the facility on [DATE] with a diagnosis of Quadriplegia.<br><br>Review of R2's medication administration record (MAR) revealed she was to received a 5 mg (milligram) and a 10 mg Baclofen (muscle relaxer) tablet, three times a day at 6:00 AM - 7:00 AM, 2:00 PM - 3:00 PM, and 10:00 PM - 11:00 PM.<br><br>Review of another medication order revealed R2 was to receive solifenacin (Vesicare-used for used to treat overactive bladder) two 10 mg tablet tablets once a day between 07:00 AM - 11:00 AM.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with R2 on 3/13/2024 at 9:55 AM, Assistant Director of Nursing (ADON) N entered R2's room with her medications, and told R2 which each pill was which included Baclofen. R2 stated to DON N that she already had taken her Baclofen that morning at 6:00 AM. ADON N stated that she would have to go check, then left and came back with the Baclofen, and stated to R2 that the morning nurse did not document or sign that she had administered her Baclofen at 6:00 AM. R2 did not take the Baclofen as she stated it was not due again until 2:00 PM. R2, upon inspection of her medications ADON N had in a medication cup, informed ADON N that her Vesicare tablets did not look right, told her the total dose was 20 mg. ADON N then left R2's room to check, and returned with another 5 mg tablet. ADON N stated she did not see that she was supposed to administer two Vesicare tablets.<br><br>Review of R2's Physician orders revealed she was to have a straight catheterization performed every four Hours.<br><br>During an observation on 3/12/2024 at 12:00 PM, of R2 receiving straight catheterization (a tube inserted into the bladder to drain urine then removed) Certified Nurse Aid (CNA) L and Registered Nurse (RN) M entered R2's room and with gloves on assisted R2 to stand up to her walker and assist her to the toilet. RN M and CNA L then assisted R2 with cleaning of R2's peri area. RN M was observed to assist R2 out of the bathroom, holding onto R2's gait belt (belt around the waist to assist with ambulation and standing) without washing their hands. RN M was observed to have the same gloves on used to assist R2 with toileting. RN M assisted R2 to sit on the bed, the was observed to go into the bathroom and wash her hands, then exit the bathroom and put on unsterile gloves, and then assisted CNA L with getting R2's pants down for catheterization. RN M was then observed to take a baby wipes and wipe R2's peri area, then toss the baby wipes and unsterile gloves into the trash. RN M was then observed to open the sterile catheter kit, however did not sanitize nor wash her hands after removal of the dirty unsterile gloves and before opening the sterile catheter kit. RN M then put the sterile gloves from the kit on and proceeded to cleanse R2's peri area with the betadine Q-Tip's, insert the catheter, drained 400 cc (cubic centimeters) of urine, and then clean up the used equipment.<br><br>In an interview on 3/12/2024 at 1:00 PM, RN M was asked what the facility policy & procedure infection control practice was regarding hand washing, sanitizing, and sterile technique. RN M did not answer the question. Upon informing RN M of a concern that was observed when she cleansed R2's peri area with unsterile gloves and did not sanitizing nor wash her hands prior to opening the sterile catheter kit, and putting on the sterile gloves, RN M just said okay, and nothing more.<br><br>In an interview on 3/13/2024 at 4:51 PM, Director of Nursing (DON) B stated that her expectation and the facility's policy and procedure required that RN M, after assisting R2 to use the toilet, should have taken her gloves of, washed her hands then proceed with assisting R2 to bed for her straight catheterization, then after wiping R1's peri area with a baby wipe RN M should have tossed those gloves into the trash, then proceed into the bathroom and used soap and water to wash hands prior to putting on the sterile gloves and opening the catheter kit. DON B also stated it was the facility's policy and procedure that staff wash or sanitize their hands in between each glove change especially from dirty to clean procedures. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446<br><br>This citation pertains to intake numbers MI000142729, MI00142630, & MI00143199.<br><br>Based on observation, interview, and record review the facility failed to provide the necessary treatment and services for pressure ulcer for three out of three residents (Resident #1, 2, & 4) to promote healing and prevent infection.<br><br>Findings Included:<br><br>Resident #1 (R1)<br><br>Per the facility face sheet R1 was admitted to the facility on [DATE]. Diagnoses include right above the knee amputation and paraplegia.<br><br>Review of a vascular (vein/artery system) Physician's (Patient Discharge Summary revealed R1 was admitted from the facility to the hospital 12/27/2024 for a right above the knee amputation. The summary revealed under discharge orders Additional Transfer Instructions, Wound site(s): left heel<br><br>-Cleans wound with mild soap and water/saline, rinse well, pat dry<br><br>-Apply Calcium Alginate to wound. (Cut to size.)<br><br>-Cover with a mepilex border.<br><br>-Change every other day<br><br>Record review of R1's physician orders dated 12/22/2023 through 3/13/2024 revealed no order was put into place for wound care to his left heel as ordered per R1's vascular Physician.<br><br>Record review of a Vascular Surgery Office Note dated 2/7/2024, revealed .Patient (R1) states he has not had any wound care offered to his left heel since being admitted (to the facility) ., and Patient will require serial debridements of left heel wound, will refer to wound care team at (name of facility) . The note also revealed, Patient may follow up as needed for heel debridements.<br><br>In an interview on 3/12/2024 at 9:10 AM, R1 stated that he had a pressure ulcer on his left heel. R1 stated that he did his own dressing changes, because no staff member had ever performed a dressing change on his left heel. R1 said he has to ask for 4x4 gauze and gauze wrap so he could change the dressing himself. R1 said he would pour saline (salt water) over his left heel wound, and change the dressing but only when the dressing was saturated. R1 pulled out a bag with 4x4 and wrap gauze dressing, and a small pink container with saline in it that had gauze over the open top of it, because the vial was open. R1 removed the dressing for observation. The observation of the wound revealed a pressure ulcer with full skin loss, approximately 6-7cm (centimeters) wide, 7 cm in width, and 0.2 cm in depth. R1 stated the ulcer was from pressure and he was admitted to the facility with it. R1 stated that when he would ask for new dressing supplies the nurses never would bring him some, so he would leave what dressing was already on the wound until he could get more.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R1's skin assessment dated [DATE] revealed, .new surgical wound from AKA (above the knee amputation) on RLE (right lower leg), scattered bruising r/t (related to) hospitalization . The assessment did not have any documentation about R1's left heel pressure ulcer.<br><br>Review of R1's skin assessments dated 1/4, 1/8, 1/21, 1/29, 2/5, 2/19, 2/26, 3/5, and 3/11/203, revealed no documentation of R1's left heel pressure ulcer.<br><br>Review of R1's Minimum Data Set (MDS) assessment dated [DATE] revealed R1's left heel pressure ulcer was not documented on the assessment.<br><br>Review of R1's care plans revealed no care plan in place regarding R1's left heel pressure ulcer.<br><br>In an interview on 3/13/2024 at 1:39 PM, Registered Nurse (RN) I, who was the MDS nurse, stated that R1's left heel pressure ulcer was not documentation on his MDS assessment, because it was never documented on R1's skin assessments so she was not aware of the pressure ulcer.<br><br>In an interview on 3/14/2024 at 9:22 AM, RN J, who was the wound care nurse stated that when R1 had returned from his 2/9/2024 vascular surgeon office visit she asked him for the paperwork, but said R1 refused to give the paperwork to her, and said R1 told her no treatments were needed for his left heel pressure ulcer. RN J said she did not look at R1's left heel because he had a shoe on. RN J stated she made no effort to contact the vascular surgeon's office for follow up order, stated the vascular surgeon did not tell her that he was referring R1 to the facility wound care team.<br><br>In another interview on 3/14/2024 at 10:30 AM, R1 stated that no nurse, including RN J, had ever asked him for the paperwork when he returned from his vascular surgeons appointment on 2/9/2024. R1 said the surgeon's office always faxed his paperwork to the facility. R1 said he has never refused to give a nurse his surgeon office visit paperwork, because the office always faxed his paperwork to the facility.<br><br>Another review of R1's surgeon's office note revealed a faxed time stamp of 2/22/2024 at 12;49 PM.<br><br>R1 further stated that his left heel pressure ulcer had necrotic tissue (dead tissue) in it when he was admitted to the facility, and said because the facility did not provide treatment to his pressure ulcer wound he put Vaseline on the wound which softened the black tissue enough for him to peel it off.<br><br>R1 also stated that he had been asking Director of Nursing (DON) B since he was admitted in December of 2023 when the Nurse Practitioner (NP) K was going to come treat his left heel pressure ulcer, and said despite continued requests to see NP K he still has never seen NP K.<br><br>In an interview on 3/14/2024 at 8:58 AM, NP K stated that she was the NP who went to the facility every Wednesday to do wound care. NP K said she was made aware by the facility that R1 had a pressure ulcer to his left heel, and therefore had never seen R1 during her facility visits. NP K said she was made aware on 3/13/2024 of R2's pressure wound, and when she assessed the wound it was a stage 2 (open wound that has broken through both the top and bottom layers of the skin) pressure ulcer.<br><br>Resident #2 (R2)<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Per the facility face sheet R2 was admitted to the facility on [DATE] with a diagnosis of Quadriplegia.<br><br>In an interview on 3/12/2024 at 11:00 AM, R2 R2 stated that she had a pressure ulcer on her right buttocks, DON B and RN K were aware if it.<br><br>Record review of R2's skin assessments dated 2/14, 2/15, 2/16, and 2/19/2024 revealed, no areas of skin impairment.<br><br>Review of R2's skin assessments dated 2/26/2024 revealed, .excoriation (damage or removed part of the surface of the skin) noted to bilateral (both sides) buttocks, light pink and blanchable (turns white with pressure then back to pink with relief of the pressure), barrier cream applied<br><br>Review of a skin assessment dated [DATE], revealed .small scab noted to right buttocks, skin is light pink and blanchable, barrier cream applied<br><br>Another skin assess dated 3/10/2024 revealed, .small scab noted to right buttocks, skin is light pink and blanchable, barrier cream applied<br><br>In an observation on 3/12/2024 at 12:00 PM, R2 was observed to have a pressure wound to her right buttocks.<br><br>Review of R2's Physician orders revealed no order for treatment to R2's buttocks pressure wound was written until 3/12/2023.<br><br>Record review of R2's active care plans revealed no care plan in place regarding R2's pressure wound to her buttocks.<br><br>In an interview on 3/13/2024 at 9:55 AM. R2 said it wasn't until 3/12/2024 that she saw NP K, and was able to tell NP K about her wound on her buttocks. R2 said NP K told her that she was never made aware of her pressure wound. R2 said no nurse had ever performed a full skin assessment on her.<br><br>In an interview on 3/14/2024 11:15 AM, DON B said that it was facility policy and her expectation that the CNA's perform a skin sweep during resident showers, and make nursing aware of any concerns. Regarding R1's left heel pressure ulcer DON B said RN J who documented his heel pressure ulcer on admission, and she expected RN J to perform weekly skin assessments.<br><br>DON B further stated that she asked the nurses' why no one had told her about R1's left heel pressure ulcer. DON B said she received no answer from any of the nurses.<br><br>Review of the facility's policy and procedure titled, PRESSURE ULCER PREVENTION AND CARE dated 6/2019 and revised on 2/2024, revealed under Procedure: 1. Nurses will complete the Skin Body Assessment Observation upon admission/readmission, then weekly as needed 5. Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution .6. Pressure injuries will be assessed and documented upon admission, readmission, upon discovery, and weekly thereafter .7. Physicians and responsible parties will be notified of pressure injury upon identification and with change in status of pressure injury.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 46955<br><br>Resident #4<br><br>Review of the medical record revealed that Resident #4 (R4) was admitted to facility 12/15/23 with diagnoses including stage 4 pressure ulcer of right upper back, pressure-induced deep tissue damage of unspecified site, quadriplegia, contracture of right/left upper arm, moderate protein-calorie malnutrition, adult failure to thrive, and degenerative disease of nervous system. Review of the Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 12/21/23 reflected a staff assessment for mental status indicating that R4 had severely impaired cognitive skills for decision making. Section GG of the MDS indicated that R4 was dependent for oral hygiene, toileting, showering, dressing, personal hygiene, bed mobility, and transfers. Section M of the same MDS reflected that R4 was admitted with unhealed pressure injuries.<br><br>In an observation on 3/13/24 at 9:46 AM, R4 was observed lying in bed positioned toward left side with positioning wedge at right upper back region. R4's bilateral upper extremities noted to be flexed inward at elbows and bilateral lower extremities flexed at knees. R4 was observed to have eyes open, smiled when name called, and shake head in response to yes or no questions but provided no verbal response.<br><br>Review of R4's medical record completed with the following findings noted:<br><br>Physician order dated 2/21/24 stated, sacrum-cleanse with dakins solution [an antiseptic solution used to cleanse and treat wounds], dry, apply skin prep around wound, apply collagen sheets to wound bed, boarder gauze, secure with tape, change daily.<br><br>Physician order dated 2/28/24 stated, R [right] and left medial feet- cleanse with NS [Normal Saline]-dry completely, apply skin prep around wound, followed by collagen sheet cover with dry dressing change daily.<br><br>Physician order dated 2/21/24 stated, R scapula- Cleanse with Dakins solution dry completely, apply skin prep around wound, apply collagen matrix sheet to wound bed and undermining, cover with boarder gauze change daily.<br><br>Further review of all physician orders was not noted to include an as needed order for wound care completion to sacrum, right and left foot, or right scapula if dressing were to become soiled or dislodged.<br><br>Review of the most recent Progress Note with an indicated Date of Service of 3/8/24 completed by the wound nurse pratitioner stated, .Right shoulder/scapula, stage IV .Treatment .Cleanse this area with saline solution or wound wash. Apply collagen sheet. Cover with bordered absorbent foam. Perform daily and as needed if soiled .Sacrum stage IV .Treatment .Cleanse with saline or wound wash. Pat dry. Apply collagen sheet. Cover bordered gauze. Perform daily and as needed if becomes dislodged .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 3/14/24 at 9:53 AM, Registered Nurse (RN) C was observed to collect multiple wound care supplies from the treatment cart including three 100 milliliter containers of Sterile Water for Irrigation and Dakins solution half strength and enter R4's room to complete treatments. R4 was observed to be lying in bed, on back, and with the assist of Certified Nurse Aides (CNAs) D and E, R4 was positioned onto left side. A bordered gauze dressing saturated with pink tinged drainage was observed at R4's right scapula region with an approximate 10 centimeter (cm) x 10 cm area of pink to tan drainage noted on the fitted sheet with RN C confirming to be drainage from scapula wound. RN C denied prior knowledge of the saturated/leaking dressing or of its need to be changed. Upon removal of dressing by RN C, open area observed with dark pink tissue in base. RN C observed to cleanse wound first with Sterile Water and then Dakins solution half strength prior to completing dressing change.<br><br>RN C was then observed to remove gauze dressing from right foot and after sanitizing hands and applying new gloves, dipped 4 x 4 gauze into open bottle of Sterile Water stating that she was going to clean the wound with the Normal Saline. RN C was then observed to clean open wound at right medial foot with prepared gauze dipped in Sterile Water prior to completing ordered dressing change.<br><br>CNA E was then observed to unfasten R4's brief exposing open sacral wound as no dressing observed to be covering wound or dislodged within open brief. Small amount of light brown stool noted at R4's rectum. R4's brief was observed to have an area of tan, blood-tinged drainage measuring approximately 6 cm x 4 cm. RN C placed barrier under R4's buttocks and proceed to cleanse sacral wound with Dakins solution half strength prior to completing dressing change. CNA D stated that she was R4's assigned CNA that date, had arrived on unit at 6:00 AM, last checked on R4 at approximately 7:00 AM and that as R4 had not had a bowel movement, did not open brief and therefore was unaware that R4's sacral dressing had not been in place. RN C also denied knowledge that the sacral wound dressing was not in place as had not been informed through report from night shift nurse or informed by the day shift CNA's yet that date and was unable to say how long the dressing had been off.<br><br>RN C was then observed to remove gauze dressing from left foot after sanitizing hands and applying new gloves, dipped 4 x 4 gauze into open bottle of Sterile Water and verbalized that she was going to clean the wound with Normal Saline. RN C was then observed to clean the open wound at left medial foot with prepared gauze dipped in Sterile Water prior to completing ordered dressing change.<br><br>In an interview on 3/14/24 at 11:15 AM, RN C stated that R4's wound care orders indicated specific orders to cleanse with either Normal Saline or Dakins solution depending on the specific wound and therefore had cleansed the indicated wounds with either Normal Saline or Dakins, per the order. Upon request, RN C reviewed the label on the bottle that she had utilized and confirmed that the label reflected Sterile Water. RN C stated that she had requested Normal Saline be delivered to the unit, that morning, as was not available on treatment cart, that Sterile Water must have been delivered instead and had not verified the label prior to use as had just assumed that Normal Saline had been delivered, as requested. RN C further stated that she believed that the treatment orders included the strength of the Dakins solution to be used, but that she could not say with certainty, and that she had used half strength Dakins solution as that was the only strength available in the treatment cart. Upon referencing R4's EMR, RN C stated that R4's orders did not indicate the strength of the Dakins solution as she would expect and therefore had just used what was available.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235174 | A. Building<br>B. Wing | 03/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Nursing and Rehabilitation Community | 575 N Madison St<br>Marshall, MI 49068 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 3/14/24 at 12:10 PM, Director of Nursing (DON) B stated that wound care orders were obtained from either the physician or the wound nurse practitioner with the expectation that the assigned nurse complete the treatment as ordered. Per DON B, wounds were cleansed as outlined in the order with either Normal Saline, Sterile Water, or wound cleanser and that the cleansing solutions should not be used interchangeably confirming that as R4's order indicated a Normal Saline cleanse, that Sterile Water should not have been used. DON B stated that orders for a Dakins cleanse or treatment did not include a specific strength, that the facility only stocked the half strength solution, and that was the solution used for all orders that included Dakins Solution.<br><br>Per DON B, clarification orders were not obtained for a Dakins strength as always just used the half strength that was stocked. DON B further stated that each wound treatment order should include a frequency of change as well as an as needed order for instances when the dressing was soiled or dislodged. Per DON B, the expectation was for all wound dressings to be routinely monitored during care completion and if observed by the CNA to be soiled or dislodged that the nurse would be immediately notified for completion of wound care at that time as leaving a wound uncovered or with a saturated/leaking dressing was not good. DON B confirmed that as day shift started at 6:00 AM, that R4's sacral dressing would have been off since prior to that time as R4's assigned day shift CNA and RN were unaware of the missing dressing. |