

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Hartford Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 W Outer Dr Detroit, MI 48235	

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 - Few</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** 38230</p> <p>Based on observation, interview, and record review the facility failed to maintain the cleanliness of a geriatric recliner for one (R78) of two residents reviewed for clean, comfortable and homelike environment.</p> <p>Findings include:</p> <p>On 11/20/24 at 6:17 a.m. R78 was observed in the common area of the unit sitting in a geriatric recliner. R78 appeared very anxious, restless, and confused. R78 legs were bent, and the lower part of the recliner was observed with dried food, dust, and candy wrappers. The left side of the recliner had dried brownish colored drip stains and the top of the recliner had a dried white substance.</p> <p>On 11/22/24 at 12:37 p.m. R78 was again observed in the common area of the unit sitting in the geriatric recliner. The recliner was observed with dried food, dust, stains, and trash as observed on 11/20/24.</p> <p>On 11/22/24 at 1:09 p.m. the Assistant Director of Nursing (ADON G) was asked to observe R78's recliner. ADON (G) was then interviewed about the cleaning of wheelchairs and recliners. ADON (G) said the chairs are cleaned on the midnight shift by the aides on shower days and as needed. Chair cleaning is assigned on the assignment sheet at the nurse's station.</p> <p>The assignment sheets were reviewed (last 7 days). The cleaning of chairs was not noted on the assignment sheets.</p> <p>Review of the clinical record document R78 was admitted into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, glaucoma, and hallucinations. According to the admission Minimum Data Set assessment dated [DATE], R78 required dependent one person assistance with activities of daily living.</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 - Few</p>	<p>Review of the facility's policy titled Cleaning and Disinfecting Multi-Use Resident Equipment dated 10/11/23 documented in part: Cleaning and disinfection are essential for ensuring that multi-use medical equipment does not transmit infectious pathogens to residents . Noncritical items are resident care items that come in contact with intact skin but not mucous membranes and include, but are not limited to: .wheelchairs . Noncritical resident care items carry very little risk of transmitting infectious agents to residents even when they come in contact with non-intact skin or mucous membranes. However, these items may contribute to secondary transmission by contaminating the hands of health care workers . Thus, reusable noncritical resident care items should undergo cleaning and disinfection when they're visibly soiled and on a regular schedule (for instance, after each use, daily or weekly), as determined by the health care facility .</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230</p> <p>Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was completed and transmitted to CMS (Center for Medicare and Medicaid) within 14 days after completion for one (R54) reviewed during the Resident Assessment review, resulting in inaccurate tracking of resident assessments (admission, quarterly, and discharge).</p> <p>Findings include:</p> <p>On 11/22/24 at 12:01 p.m., review of the clinical record revealed R54 had an Admission MDS assessment with an assessment reference date (ARD) of 7/1/24. This MDS documented that it had been Completed (7/10/24); locked and accepted on 7/23/24. R54 discharged from the facility on 7/19/24. Review of the discharge MDS assessment revealed the assessment was not completed or submitted which was indicated on the resident assessment as MDS Record over 120 days. Review of the MDS tracking located in the MDS tab in the electronic medical record read, Next Tracking/Discharge: Discharge- ARD: 7/19/24, 112 days overdue.</p> <p>On 11/22/24 at 1:17 p.m., the MDS Coordinator (Nurse D) was interviewed. MDS Nurse D acknowledged the discharge assessment was not completed and said they were uncertain why the assessment was missed.</p> <p>Review of the RAI (Resident Assessment Instrument 3.0) [NAME] dated October 2024 documented in part: Responsibilities of Nursing Homes for Completing Assessments- The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source . An RAI (MDS) must be completed for any resident residing in the facility .An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</p> <p>Based on observation, interview, and record review the facility failed to provide timely ADL (Activities of daily living) care to include nail care and beard care for one resident (R28) of three residents reviewed for ADL care resulting in dissatisfaction with care.</p> <p>Findings include:</p> <p>On 11/20/24 at 9:07 AM R28 was observed in bed with long fingernails with debris and an unkempt beard. R28 stated I could use a shave and get my nails cut.</p> <p>On 11/21/24 at 8:41 AM R28 was observed with long fingernails with debris and an unkempt beard.</p> <p>Record review of R28's Electronic Health Record (EHR) revealed admitted to facility on 1/28/22 with pertinent diagnosis of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following cerebral infarction (stroke) affecting right dominant side.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] for R28 revealed a Brief interview for Mental Status (BIMS) of 13/15 intact cognition and substantial/maximum assistance for personal hygiene.</p> <p>On 11/21/24 at 2:08 PM R28 was observed with Licensed Practical Nurse (LPN) B. LPN B agreed R28's fingernails were long with debris and his beard was unkempt. R28 agreed to have his nails cut and beard trimmed when offered by LPN B. LPN B said usually nails are cut and beards are trimmed when residents are given bed baths/showers.</p> <p>Record review of R28's care plan dated 11/5/24 revealed Resident requires limited assistance with one staff assistance with personal hygiene and oral care.</p> <p>Record Review revealed no resident refusals of ADL care in the EHR and R28 received a bed bath/shower on 11/20/24 at 19:43 (7:43 pm.)</p> <p>On 11/22/24 at 9:35 AM the Director of Nursing (DON) was interviewed and said ADLs are expected to be performed as needed for residents.</p> <p>Review of the facility policy titled Routine Resident Care revised 3/7/23 revealed in part .Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene. Daily personal hygiene minimally includes assisting residents with washing their face and hands, shaving, nail care, combing their hair each morning. Any concerns will be reported to the nurse.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</p> <p>Based on interview and record review the facility failed to include one resident (R93) out of four residents reviewed for limited ROM in the restorative program.</p> <p>Findings include:</p> <p>On 11/20/24 at 12:38 PM, R93 was interviewed while in bed and stated, I'm not getting therapy or any exercises. I was supposed to get exercises after therapy finished.</p> <p>Record review of Electronic Health Record (EHR) revealed R93 admitted to the facility on [DATE] with diagnoses that included acquired absence of right leg below knee, absence of left leg below knee.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] for R93 revealed a Brief interview for Mental Status (BIMS) 15/15 intact cognition and substantial/maximal assistance for transfers.</p> <p>Record review of the physical therapy discharge summary note dated 11/1/24 revealed RNP/FMP (restorative nursing program/functional maintenance program): to facilitate maintaining current level of performance and in order to prevent decline, development of an instruction in the following RNP has been completed with the idt (interdisciplinary team): bed mobility and transfers.</p> <p>Record review of the occupational therapy discharge summary dated 11/12/24 revealed RNP/FMP to facilitate maintaining current level of performance and in order to prevent decline development of and instruction in the following RNPs has been completed with the IDT:ROM (range of motion) (active).</p> <p>Record review of the EHR did not reveal a therapy to restorative form completed for the physical therapy discharge on 11/1/24.</p> <p>Record review of the occupational therapy to restorative form completed on 11/10/24 revealed teaching received by nursing signed by Licensed Practical Nurse C.</p> <p>Record review of the restorative assessment was made on 11/13/24.</p> <p>Further review of the EHR for R93 revealed no orders, care plan and/or Kardex for a restorative ROM program.</p> <p>On 11/21/24 at 12:40 PM Licensed Practical Nurse/Restorative Nurse (LPN) C was interviewed and said R93 was not on restorative nursing services but based on the documentation in the EHR (R93) should be. LPN C said physical therapy did not send over a referral for restorative services. LPN C said she receives a therapy to restorative form then does an assessment and based on the restorative assessment restorative services would begin within three business days.</p> <p>On 11/22/24 at 9:35 AM the Director of Nursing (DON) was interviewed and said the expectation is that restorative services should be assessed per therapy recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Restorative Nursing revised 4/26/24 revealed in part: The facility strives to enable the resident to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. A licensed nurse will manage the restorative nursing process with assistance of nursing assistants trained in restorative care. Nursing restorative is available up to 6-7 times per week. Components of the restorative nursing program include interdisciplinary process: a referral from skilled therapy services via the Therapy to Restorative Program Plan, and/or during weekly interdisciplinary Team Meeting.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230</p> <p>Based on observation, interview, and record review the facility failed to ensure respiratory care equipment was stored in a sanitary manner for one resident (R276) out of two residents reviewed for respiratory care resulting in the potential for respiratory infections.</p> <p>Findings include:</p> <p>On 11/20/24 at 10:23 a.m. R276 was observed sitting in a wheelchair, in the room. R276 was alert, oriented to person, place, situation, and able to make all needs known. On the nightstand, a CPAP machine (A continuous positive airway pressure device used for treating sleep apnea disorders.) mouthpiece and tubing was observed loosely wrapped around machine with the mouthpiece resting on the nightstand's surface uncovered. R276 was queried about the uncovered mouthpiece and stated, The other places have always given something to put over it to keep from getting dirty but not here. It has fallen on the floor. I just pick it up and put back on the table. Sometimes they clean it in the morning but not before I put it on at night.</p> <p>On 11/20/24 at 12:51 p.m. R276 was observed attempting to move the wheelchair and bumped the nightstand in which the uncovered mouthpiece fell and landed on the floor. R276 picked the mouthpiece off the floor by grabbing the tubing and placed it back on the nightstand.</p> <p>Review of the clinical record documented R276 was readmitted into the facility on [DATE] with diagnoses that included obstructive sleep apnea. R276 required extensive one person assistance with activities of daily living and had intact cognition.</p> <p>Review of the physician's orders documented:</p> <p>Clean tubing and mask with soap and water, rinse with water, and let air dry. One time a day every 7 day(s). Start date: 10/3/2024.</p> <p>Review of care plans documented the following:</p> <p>Resident has a potential for difficulty breathing and risk for respiratory complications R/T: Obstructive Sleep Apnea. 10/4/2024</p> <p>Interventions:</p> <ul style="list-style-type: none"> -Administer medication & treatments per physician orders. - Observe for s/sx (signs and symptoms) of respiratory infection. <p>Review of the November 2024 medication treatment record (MAR) documented the cleaning of the CPAP tubing and mask was on 11/14/24. There was no other documentation of additional cleanings.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/22/24 at 1:13 p.m. Unit Manager G was interviewed and queried how are CPAP machine mask stored when not in use. Unit Manager G said the mask are placed in a plastic bag when not in use however a company provides them. The nurses are responsible for proper storage of the mask when not in use. Unit Manager G was unaware R276 did not have the proper covering for the CPAP mask.</p> <p>Review of the facility's policy titled Use of Oxygen (also used for CPAP and BIPAP) dated 8/17/21 documented in part the following: The mask should be changed weekly and dated. It should be changed when soiled or dirty . The mask, when not in use, should be stored in a clean bag .</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230</p> <p>Based on observation, interview, and record review the facility failed to ensure routine dental services were provided to one resident (R63) of three residents reviewed for routine dental services, resulting in unmet oral health needs, discomfort, and loss of dignity.</p> <p>Findings include:</p> <p>On 11/20/24 at 9:45 a.m. was observed in bed resting. R63 presented as alert, oriented to person, place, and situation. R63 stated, I don't like the food here. I get soft food because I have trouble chewing. I asked to see a dentist, but no one has said anything about an appointment to see one. R63 pulled the bottom lip down and exposed two teeth (no other teeth except the two shown). R63 stated, I want these last two teeth pulled so I can get dentures and go back to a regular diet. I'm not eating like I want to. I eat more outside food. I want to gain more weight, but I can't if I'm not eating. If I can get them pulled, I will grin from ear to ear like a [NAME] cat. R63 confirmed being in the facility for about two months.</p> <p>Review of the electronic medical record documented R63 was admitted into the facility on [DATE] with diagnoses that included prediabetes, severe protein-calorie malnutrition, peripheral vascular disease, and chronic obstructive pulmonary disease. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R63 was cognitively intact with a BIMs score of 15 and required one- person assistance with activities of daily living. The MDS assessment also documented in the Oral Health and Swallowing section as No natural teeth or tooth fragment(s) (edentulous).</p> <p>Review of the Oral/Dental care plan dated 9/16/24 documented: The resident is at risk for infection, pain or bleeding in the oral cavity, has oral/dental health problems r/t: missing teeth. Interventions: Coordinate arrangements for dental care, transportation as needed/as ordered. Observe/document/report to physician PRN s/sx of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions.</p> <p>Review of the Physician Orders dated 9/7/24 documented:</p> <p>Dental evaluation and treatment as indicated.</p> <p>On 11/21/24 at 4:18 p.m. the Director of Nursing (DON) and Social Service Director (SSD H) were interviewed about the delay with R63 receiving dental care. The DON said any department can refer for dental. Social Service ensures they are seen by the dentist. The DON and SSD H said they were unaware the resident needed dental care because the resident did not verbalize needing dental care. The DON acknowledged there was a physician order for a dental evaluation, however said the order was a standard order (an order written IF needed). The DON also acknowledged a dental care plan was developed identifying dental concerns, however said the care plan did not necessarily mean there was dental concerns that needed to be addressed.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>SSD H said dental services were not offered to the resident while conducting the initial assessment upon admission. SSD H also said the resident did not want to see the dentist, however there was no documented evidence the resident declined dental services.</p> <p>On 11/21/24 at 4:35 p.m. Registered Dietician (RD) E was interviewed and said R63 dental status was documented in the admission nutrition evaluation (dated 9/10/24) c/o difficulty chewing. R63 was changed to a mechanical soft diet due to indentation. The resident was edentulous (except two teeth) but did not express wanting dental care to get dentures.</p> <p>Review of the facility's policy titled Dental Services effective 11/4/24 documented in part: The facility will provide, or obtain from an outside resource, routine and twenty-four (24) hour emergency dental services to meet the needs of the resident and when requested by the resident.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>50634</p> <p>Based on observation, interview and record review the facility failed to ensure resident equipment was cleaned and sanitized sanitary equipment for 14 of 14 residents that resided on the third floor.</p> <p>Findings Include:</p> <p>On 11/22/24 at 9:00AM, a shower chair was observed in the hallway with visible dried feces. In addition, the sit to stand machine (device used for positioning residents) was noted to be soiled with dirt and food particles.</p> <p>On 11/22/24 at 9:10 AM, LPN A was queried concerning who was responsible for cleaning the resident's equipment. LPN A indicated the equipment should have been cleaned by the midnight shift. LPN A further indicated the equipment should have been cleaned after each use to prevent cross contamination.</p> <p>On 11/22/24 at 9:20 AM, the Nursing Home Administrator, (NHA) was shown the shower chair while she was rounding on the unit. The Administrator reiterated after observing the shower chair the facility was responsible for cleaning the equipment and the equipment should be cleaned after each use and on the midnight shift. A request for the facility's policy on cleaning equipment was made at this time.</p> <p>On 11/22/24, record review of the facility's policy entitled Cleaning and Disinfecting Multi-Use Resident Equipment dated 10/11/23 documented in part: Cleaning and disinfection are essential for ensuring that multi-use medical equipment does not transmit infectious pathogens to residents . Noncritical items are resident care items that come in contact with intact skin but not mucous membranes and include, but are not limited to: .wheelchairs . Noncritical resident care items carry very little risk of transmitting infectious agents to residents even when they come in contact with non-intact skin or mucous membranes. However, these items may contribute to secondary transmission by contaminating the hands of health care workers . Thus, reusable noncritical resident care items should undergo cleaning and disinfection when they're visibly soiled and on a regular schedule (for instance, after each use, daily or weekly), as determined by the health care facility</p>		