STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235192	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Standish Hospital & Skilled Nursing Fac	805 W Cedar Standish, MI 48658

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 22927 Based on observation, interview and record review, the facility failed to ensure that a call bell communication device was responded to for two residents (#9, #72), of 22 sampled residents, resulting in Resident #9 and #72 being seated in the dining room with a silver metal service bell which was rung with no response from facility staff. Findings include: Observation on 2/19/2025 during the initial tour of the facility resident dining room at the noon meal revealed that there was no electronic call bell system with resident push buttons noted in the dining room area. Observation and interview was made on 02/19/25 at 09:34 AM with Resident #9 who stated that she was thirsty and wet (wet brief) and wanted to lay down. Resident #9 was observed with a silver metal service bell in dining room on the table. Resident #9 was able to demonstrate ringing the bell which rang 3-4 times. The State surveyor observed two staff members seated across the hall at the nursing station, Certified Nurse Assistant (CNA)/ward clerk H and Registered Nurse (RN) E. Neither staff member responded to see what the resident needed. The state surveyor went out into the hallway to look and see if there were other staff members available. Resident #9 stated to yell out while she was seated in the dining room to get attention of the staff. On 02/19/25 at 09:52 AM, Certified Nurse Assistant (CNA) B came into the room when Resident #9 was yelling out to get attention. CNA B asked Resident #9 what she needed and then Brought the resident a glass of water. The state surveyor asked CNA B about the manual silver call bell on the table and the response was if she (Resident #9) needs something, she will just yell out. Observation was made on 02/19/25 at 10:21 AM with Certified Nurse Assistant (CNA) B and Registered Nurse (RN) D of a Hoyer transfer of Resident #9 back to bed, a brief change and peri-care. Observation on 02/20/25 at 11:38 AM of the dining/TV room revealed Resident #9 and #72 and 6 other residents seated in the room with only a silver manual call bell on one table. No staff were present. The silver manual call bell was located in the middle of a large round table and out of reach of both Resident #9 and Resident #72, who were seated at the table. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility 'Emergency/Call Bell' policy and procedure, dated 4/5/2024, revealed the purpose was to establish guidelines to alert staff when the call light system is down, or when a resident is in a non-centralized location without a call light system. To provide safety for all residents of the skilled nursing unit, and to ensure that residents needs are being met . Call bells will be located in non-centralized areas that do not have a call light system. When needed call bells will be placed within the resident's reach at all times when in their rooms or in non-centralized locations without a call light system . All staff are to respond as promptly and as soon as possible to call bells . Observation on 2/20/2025 of the Resident/Family visitor lounge revealed that there was a manual silver call bell located on a table. The state surveyor rang the bell and staff did not respond to the bell.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to provide for safe wheelchair transport for two residents (#7 and 17) of two residents reviewed, resulting in residents being pushed in wheelchairs without footrests and the potential for injury. Findings include: Resident #7: On 2/19/25 at 10:14 AM, Activity Staff L was observed pushing Resident #7 down the hallway in their wheelchair without footrests. Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included dementia, anxiety, left hip injury, and bone density disorder. Review of the Minimum Data Set (MDS) assessment, dated 1/31/25, revealed the Resident was severely cognitively impaired and required substantial assistance with toileting, personal hygiene, and dressing. The MDS specified the Resident was independent with wheelchair mobility. Review of Resident #7's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #7) is at risk of falls r/t (related to) history of falls, weakness (Start Date: 11/18/23; Edited: 1/28/25). Resident #17: On 2/20/25 at 10:32 AM, Certified Nursing Assistant (CNA) M was observed pushing Resident #17 down the hallway in their wheelchair without footrests. At 11:44 AM on 2/20/25, CNA M was observed pushing Resident #17 down the hallway in their wheelchair without footrests again. Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses which included depression, dementia, anxiety, and repeated falls. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required substantial to total assistance with toileting, personal hygiene, and dressing. The MDS specified the Resident was independent with wheelchair mobility. An interview was completed with the Director of Nursing (DON) on 2/20/25 at 2:02 PM. When queried regarding staff pushing residents down the hallway in wheelchairs, the DON stated, Should have foot pedals. Observations of Resident #7 and Resident #17 being pushed without footrests/pedals were discussed with the DON at this time. The DON reiterated foot pedals should always be utilized when pushing residents in wheelchairs for safety but did not provide further explanation. Review of facility provided policy/procedure entitled, Transportation Guidelines for LTC Residents (Effective: 1/2025) did not address wheelchair mobility/transport.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to implement and operationalize policies and procedures for psychotropic medication use for one resident (Resident # 7) of five residents reviewed resulting in a lack of appropriate diagnoses and indications for treatment, a lack of Gradual Dose Reductions (GDR), and the potential for ineffective and inappropriate treatment. Findings include: Resident #7: On 2/19/25 at 10:00 AM, Resident #7 was observed sitting in their wheelchair in their room with a forlorn look on their face. An interview was completed at this time. When asked how they were doing, Resident #7 made eye contact but did not provide a verbal response. When asked if they were sad, Resident #7 shook their head yes and began to cry. On 2/19/25 at 10:05 AM, the Director of Nursing (DON) was informed the Resident began crying when asked if they were sad but did not provide any information regarding the reason they were sad. The DON stated, That is (Resident #7's) normal. (Resident #7) startles easy. With further inquiry, the DON stated, Anything or anyone new and (Resident #7) begins to cry. The DON was then asked if the Resident was receiving behavioral health services and treatment and responded that they were not. Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance and with anxiety, Chronic Obstructive Pulmonary Disease (COPD), and bone density disorder. Review of the Minimum Data Set (MDS) assessment, dated 1/31/25, revealed the Resident was severely cognitively impaired and required substantial assistance with toileting, personal hygiene, and dressing. The MDS specified the Resident displayed no behaviors and no signs/symptoms of depression. The MDS assessments. dated 5/1/24 and 10/31/24. also specified the Resident displayed no behaviors. An interview was completed with Certified Nursing Assistant (CNA) P on 2/20/25 at 10:38 AM. When queried regarding Resident #7, CNA P stated, (Resident #7) gets upset easy and indicated the Resident cries frequently for no reason. CNA P verbalized Resident #7 has a history of trauma but was unable to provide any additional information related to the type of trauma and/or triggers. Review of Resident #7's Electronic Medical Record (EMR) revealed the Resident was deemed incompetent to make medical decisions on 8/11/24. A review of Resident #7's Medication Administration Record (MAR) and Health Care Provider (HCP) orders revealed the Resident was taking the following psychotropic medications: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Buspirone (Buspar- anti-anxiety medication) . 10 mg (milligrams) . Every 12 hours . (for) Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety . (Start Date: 11/18/24) - Fluoxetine (Prozac- antidepressant medication) . 20 mg . at bedtime . (for) Unspecified dementia . with anxiety . (Start Date: 11/18/24) Review of Resident #7's EMR revealed a care plan entitled, Psychotropic Drug Use . Resident is at risk for adverse consequence from receiving psychotropic medication: Prozac, Buspar (Start Date: 8/28/24; Edited: 1/28/25). The care plan included the interventions: - Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms (Start Date: 8/28/24) - Attempt a gradual dose reduction (if not contraindicated) (Start Date: 8/28/24) - Attempt to give the lowest dose possible (Start Date: 8/28/24) - Monitor resident's behavior and response to medication. Prior to starting Prozac would have multiple outbursts of crying, shaking, saying 'I'm sorry' repeatedly and 'please don't hurt me'. (Start Date: 8/28/24) - Try non-pharmacological interventions before initiating drug therapy. Staff approach from the front. Talk . throughout any cares given explaining each step prior to completing (Start Date: 8/28/24) An interview was conducted with Social Services Designee (SSD) Registered Nurse (RN) A and the Director of Nursing (DON) on 2/21/25 at 9:38 AM. When queried regarding the facility policy/procedure related to informed consent for psychotropic medications, SSD RN A revealed a paper consent is obtained. When asked where Resident #7's consent was located as it was not noted in their EMR, SSD RN A revealed they were having issues scanning paper documents into the EMR and indicated they the paper consent form. SSD RN A provided a paper Informed Consent/Risk Benefit Analysis form for Prozac for Resident #7. The form detailed the Reason for use and benefits expected: anxiety, tearfulness, crying out . The form was signed by Resident #7 and a facility RN on 8/12/24. The Form included a section for physician documentation which detailed, Doctor's Statement: I have reviewed and recommend the medication plan and included the following areas for the physician to check as completed, Resident gives consent to take these medications . Resident gives verbal consent, but unwilling/unable to sign . Emergency. Given medication without consent . Unable to understand risks and benefits, therefore cannot consent . other . comments . The Physician signed the form on 8/23/24 but all the sections were blank (not checked). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A consent for Buspar was also provided by SSD RN A. The consent form specified, Reason for use and benefits expected: decreased anxiety . The consent form indicated verbal consent was obtained by the Resident's Durable Power of Attorney (DPOA) on 10/25/24. When queried why the consent for Prozac was signed by the Resident on 8/12/24 when they were deemed incompetent to make medical decisions on 8/11/24, SSD RN A stated, I really can't give you that answer. When asked if a resident who is deemed incompetent is able to provide consent for psychotropic medications, SSD RN A verified they cannot. When queried if Resident #7 was seen by a mental health provider, SSD RN A replied, No. SSD RN A was asked of the facility had a mental health provider who came to the facility and stated, No. SSD RN A then stated, We would have to send them out to community mental health if needed. When asked if Resident #7 goes out to see community mental health, SSD RN A stated they do not. When asked why they do not, RN A replied, (DPOA) does not want (Resident #7) to go out because leaving is scary to them. RN A then stated, I can't even get the notes from (community mental health) when residents do go out for treatment. When asked how they are able to coordinate care if they are not able to get notes, RN A did not provide an explanation. When asked, SSD RN A indicated the Resident's physician manages psychotropic medications. When asked if unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety is an appropriate indication for use for Buspar, both the DON and SSD RN A indicated they were unable to provide comment or explanation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22927 Based on observation, interview and record review, the facility Failed to 1) Ensure that kitchen food items are dated with received by dates and use by dates and 2) Ensure that foods brought into the facility from family are dated, resulting in an increased likelihood for food borne illness with the potential to affect 22 Residents residing at the facility who consumed oral nutrition from the kitchen. Findings include: Review of the U.S. Public Health Service 2009 Food Code, as adopted by the Michigan Food Law, effective 10/1/2012, directs that open or partially used foods that are refrigerated. ready-to-eat and potentially hazardous are required to have use-by-date or date to be consumed. During the initial tour of the facility kitchen done on 2/19/2025 from 8:50 AM through 10:00 AM accompanied by Certified Dietary Manager I, the following was identified: Observation and interview on 02/19/25 at 08:50 AM with Certified Dietary Manager (CDM) I, of the line of in kitchen refrigerators revealed in a refrigerator clear elongated manual thermometers to be reading 8 degrees, and the outside thermometer reading of 38.4 degrees. Observation of the next in line refrigerator observed in refrigerator thermometer of 5 degrees and when checked electronic thermometer 38.8 degrees. Observation of the in refrigerator clear elongated manual thermometers were noted to be clipped to the front of the shelves next to the refrigerator doors and not in the middle of the refrigerator for a more accurate temperature. Observation and interview on 2/19/2025 at 9:10 AM with CDM I of the bread rack in the kitchen noted a full 12 pack bag of hamburger buns and a partially used bag with 4-6 buns left in the bag to be located on the top shelf with no use-by-date noted. The CDM I stated that those should have had a date on them and tossed the unmarked items out. Observation and interview on 02/20/25 at 10:17 AM with CDM I of the dry storage area and walk-in cooler freezer area revealed three (3) 16 oz. bags of marshmallows not dated and out of the manufactures box. CMD I stated that the marshmallows should have a received by date on those, but they are out of the box, and we now don't know when they came in or how old they are. The CDM I stated that everyone is responsible for dating the food items. Either she or the Supervisor assist in the shipments and putting items away. We do mark the boxes that the items come in when placing in the dry goods area. Record review of the facility 'Food and Supply Storage' policy, dated 1/2024, revealed all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption . Cover, label, and date unused portions and open packages. Complete all sections on a touchpoint orange label or use and approved labeling system. Products are good through the close of business on the date noted on the label . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 02/19/25 at 1:40 AM, Registered Nurse (RN) C was observed with the zip lock bag of 5-6 tangerines going into the Director of Nursing (DON) office . Observation on 02/20/25 at 10:30 AM of the Resident pantry refrigerator located in the resident/family dining room revealed the zip lock bag of 5-6 tangerines labeled with resident's name with no date and a box of blueberries 12 oz with the resident's hospital name tag on the box but there was no orange sticker of use-by-date. In an observation and interview on 02/20/25 at 10:54 AM with the Director of Nursing (DON, the state surveyor walked to the resident/family dining room refrigerator and observed the bag of 5-6 tangerine undated, and the box of blueberries undated. The DON stated that there should have been dates put on when placed in the refrigerator. Both items were tossed out by the DON at this time and resident name label form hospital was not removed. An interview was conducted on 02/20/25 at 11:23 AM with Certified Dietary Manager (CDM) I. When asked about foods brought into the facility and placed in the Residents/family dining room refrigerator, it was stated that food brought in from outside/family items we (facility) follow policy. Record review of the facility 'Food Brought in to Patients from the Outside' policy ,dated 4/2024, revealed: 1.) the patient/resident food must be clearly labeled with the patient/resident's name, room number, and date the food was brought to the patient/resident. If not eaten within 3 days, the refrigerated foods should be discarded . 2.) When food/beverages have been labeled with patient/resident identification, this label and product are now considered 'protected health information' (PHI) and will need to be disposed of appropriately .