STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Bloomfield Hills	2975 N Adams Road Bloomfield Hills, MI 48304

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00145592 Based on observation, interview, and record review, the facility failed to promote self-determination and allow one (R802) of three residents reviewed for resident rights, who was his own responsible party, to make his own decision to go on a leave of absence in the community, resulting in the resident feeling angry and distressed about possible loss of personal items in a storage unit after police were called and the facility staff threatened commitment to a psychiatric unit if he tried to leave the facility. Findings include: A review of a complaint submitted to the State Agency revealed allegations that noted, .(R802) attempted to leave the facility around 12/30/2023 but was told he could not leave without a guardian's permission. Veteran (R802) states he does not have a legal guardian, was not provided with any information regarding this guardian, and a quick check of (county) probate court records did not reveal any open guardianship cases for this Veteran .he states he has made his complaints known to the facility social worker (Social Services Staff - SS 'J') . (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at approximately 11:30 AM, R802 was interviewed. R802 was observed to be ambulatory and chose to stand for the interview. R802 answered questions appropriately, despite some tangential thinking (excessive, off topic speech) and statements regarding various conspiracy beliefs, R802 was easily redirectable to the topic being discussed and appeared to understand the questions and answered appropriately and consistently throughout the interview. Without prompting, R802 reporting feeling he was being held against his will at the facility and that the social worker kept telling him he had a guardian, but he had never been provided with any information that verified he had a guardian and he did not believe he had one. R802 reported that his medical provider has only spent minutes here and there with him and he could never get in contact with SS 'J'. R802 explained on 12/30/23, after attempting to contact SS 'J' without success, he contacted a ride share company to take him to his storage unit as he wanted to check on it after being evicted from his apartment and having concerns about his belongings. He had some clothing and other items that he wanted to bring back. R802 further reported that there were emergency vehicles outside of the facility and he was not sure if they were there for another resident. R802 said he had some of his belonging packed up on his wheelchair, but he did plan on returning to the facility after he went to the storage unit. Staff asked him where he was going and he told them to the storage unit. R802 reported he tried to make arrangements with SS 'J' but never heard back. Staff told him that he could not leave the facility without permission from his doctor and guardian. R802 said he did not have a guardian and walked out of the building because his ride was going to be there. According to R802, the police were coming in and staff were trying to talk to them on the side and staff told them R802 was not in any shape to leave. R802 explained that he was aware of his medical issues (wound on his leg after having surgery) but he was afraid of losing his property. When queried about whether he ever went to court regarding guardianship, R802 reported he did not and never received any paperwork regarding a hearing or guardianship. R802 reported he requested guardianship papers from the current social services director (SSD 'A'), but he was not presented with anything. R802 reported that he had no idea he would be stopped from leaving that day. R802 further reported that staff told him that if he tried to leave the facility, they would take him to jail. A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: peripheral vascular disease (PVD) and history of traumatic brain injury. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had intact cognition, no delusions or hallucinations, and no behaviors. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R802's progress notes revealed a General Progress Note dated 12/30/23 that read, Writer came out of a patient's room and saw that the patient (R802) was loading his wheelchair up with his personal belongings. Writer asked the patient where was he going and he stated that he was going to his storage unit. Writer asked patient why was he leaving, patient responded stating he was leaving cause <sic> he had things to handle. patient stated he was not going to stay here due to him having to get to his storage. Writer told patient that we would have to contact his (physician), writer (resident?) said he did not care cause <sic> his ride was on the way. Patient proceeded to leave the unit, writer used cell phone to call (Nurse Practitioner - NP 'N'), to advise that patient was leaving AMA (against medical advice). NP states that patient can not leave due to him being deemed incapable of keeping himself safe. NP states that if patient continues to leave, call police. Writer followed patient to the front and as staff was coming in patient was able to get out the building. Staff attempted to get patient back into the building but patient refused. Writer called 911 for assistance. 911 was able to get patient back into the building but patient states he needs to leave. Patient states he has to get to his storage unit and if he can not leave it will be problems for staff. Police asked patient where he will live and patient unable to answer stating he is going to his storage unit. 911 called NP back and asked for orders to keep patient, unable to give. NP states that if patient leave to call 911 and have him set to hospital for psych hold. 911 was able to convince patient to stay in facility until after NP MD (Medical Doctor) sees him. Patient was advised that if he attempts to leave later then facility will be putting him on a psych hold (involuntary) via ER (emergency room) .Unit Manager, DON (Director of Nursing), Weekend supervisor aware of situation . A review of R802's full clinical record revealed no evidence of a legal guardian or a competency evaluation as of 12/30/23. On 7/29/24 at 1:19 PM, an interview was conducted with SSD 'A'. SSD 'A' reported she began working in the facility in May 2024 and was familiar with R802. When queried about whether R802 had a legal guardian, SSD 'A' reported he did not. SSD 'A' reviewed R802's clinical record and reported R802 was deemed incompetent to make decisions on 3/5/24, but did not have guardianship in place. When queried about whether a resident who was not deemed incompetent and did not have a legal guardian had the right to leave the facility, SSD 'A' reported they did have the right. SSD 'A' did not work in the facility on 12/30/23 when R802 wanted to go to the storage unit. On 7/29/24 at 2:27 PM, an interview was conducted with the DON. The DON denied having knowledge of what occurred when R802 attempted to go to his storage unit on 12/30/23. On 7/29/24 at 2:46 PM, an interview was conducted with the Administrator. The Administrator did not work at the facility on 12/30/23. When queried about whether a resident who was not deemed incompetent to make decisions and who did not have a legal guardian could make a choice to leave the facility on a leave of absence, the Administrator reported they could. The Administrator reported R802 mentioned what happened on 12/30/23 and since he became Administrator he was trying to assist him with getting to the storage unit, but it had not yet occurred. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 3:40 PM, an interview with NP 'N' was conducted over the telephone. When queried about why she told the nurse on 12/30/23 that R802 was not allowed to leave the building and if he attempted he would be put on a psychiatric hold, NP 'N' reported she did not really remember, but she would have gone off of what was told to her by the social worker. NP 'N' said R802 seems with it when you talk to him, but doesn't have full insight into his medical situation. NP 'N' further said R802 was very unhappy and did not want to be at the facility. NP 'N' was not aware that R802 was not deemed incompetent on 12/30/23 and did not have a legal guardian. A review of a document titled, Determination of Inability to Participate in Complex Decision Making a physician (on 3/12/24) and a psychologist (on 3/5/24) determined R802 was unable to participate in making medical treatment and/or financial decisions. There was no capacity evaluation prior to that date.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number: MI00145554 and MI00145592. Based on observation, interview, and record review, the facility failed to conduct a thorough and accurate skin assessment, clarify discharge instructions from the hospital and facility orders for wound treatment, implement and administer wound treatment according to hospital discharge instructions, and ensure coordination between the wound provider and the surgeon for one (R802) of one resident reviewed for wounds, resulting in infection and the need for antibiotics. Findings include: A review of a complaint submitted to the State Agency revealed an allegation that R802's wound care was not provided daily. A review of a second complaint submitted to the State Agency revealed an allegation that R802 had wounds and cellulitis (a bacterial skin infection) that were not being addressed. On 7/29/24 at approximately 11:30 AM, an interview was conducted with R802. R802 was observed in his room. His lower legs were discolored. R802 reported prior to coming to the facility, he had a procedure on his left leg in the hospital. R802 reported when he got to the facility, he was not given any information and there were a couple days where they did not provide wound care to the leg he had a procedure on. R802 expressed dissatisfaction with the medical providers in the facility and said they only spend a minimal amount of time with him. R802 reported his experienced severe pain in his left leg after the procedure. R802 stated, The pain was 20 or 30 out of 10! A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: peripheral vascular disease (PVD). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had intact cognition, frequent pain, and no surgical or venous wounds. A review of an After Visit Summary from the hospital for R802 revealed the following documentation: .Patient Instructions .Special Instructions .Please change the wound dressing and keep the wound clean and dry. Perform daily packing changes; silvadene cream (applied to surrounding skin, not into I&D/incision site), dressing changes per nursing as needed .Start silver sulfadiazine 1 (percent) cream .apply to affected area once daily .Follow up with orthopedic surgery in 2 weeks for wound and packing checkup . A review of R802's hospital transfer records provided to the facility revealed the following: A Medication Administration Report (MAR) dated 11/11/23-11/17/23 that listed silver sulfadiazine 1 percent cream daily to LLE (left lower extremity). An Orthopedic Surgery Consult dated 11/13/23 documented, .Discussed with the patient that incision and drainage (I&D) of the fluctuant (soft and wave like when pressed indicating the presence of pus beneath the surface) area was indicated at this time .incision and drainage of the area of fluctuance was performed .a sample of the fluid was taken for culture .No purulent drainage .Daily packing changes . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Infectious Diseases consult dated 11/14/23 documented, .LLE wrapped s/p (status post) I&D .low suspicion for cellulitis at this time .His cardiac hx (history) of PVD makes chronic venous insufficiency with stasis dermatitis a more likely diagnosis for his LLE symptoms .Discontinue antibiotics . An Orthopaedic Surgery Brief Progress Note dated 11/15/23 documented, .Patient states that the pain in his leg is worse than it was before his bedside I&D .He has been receiving daily iodoform gauze packing changes and has ha silvadene ointment applied to the skin of this left leg excluding the site of I&D .compared to exam on 11/13: Decreased swelling and edema compared to prior exam .S/P bedside debridement of tissue, with packing in place with ss (serosanguinous) discharge on packing .Continue local wound care . Daily packing changes; silvadene cream (applied to surrounding skin, not into I&D site . A review of a Skin Observation Tool dated 11/17/23 (R802's date of admission) revealed no documented skin alterations. A review of a Nursing Admission Screening/History assessment dated [DATE] revealed R802 was admitted from the hospital for cellulitis. There were no documented skin alterations on the assessment. A review of Physicians Orders revealed the following: An order for Silver Sulfadiazine Cream 1% Apply to affected areas topically every shift for prevent wounds ordered 11/17/23 and discontinued on 11/21/23. An order for Silver Sulfadiazine .apply to LLE topically every day shift for wound care Cleanse with ns (normal saline), apply silvadene, cover with ABD (5x9 abdominal sized dressing) and Kerlix QD (every day) was ordered on 11/22/23. It should be noted that the special instructions noted in the hospital after visit summary to pack the wound and to not apply the silver sulfadiazine to the I&D site were not specified in the orders at the facility. A review of R802's MAR from November 2023 revealed no wound treatment was done at 7:00 AM or 7:00 PM on 11/19/23 as evidenced by documentation of 9 which indicated to see Nurse Notes. A review of the progress notes revealed on 11/19/23 at 1:19 PM, the nurse did not document a reason for the treatment not being administered. A note dated 11/20/23 at 4:06 AM documented, Not sure where to put. (It should be noted that the original order did not specify the site of the wound). Further review of the MAR revealed wound treatment was not administered on 11/21/23 and 11/22/23. A review of R802's progress notes revealed the following documentation: On 11/17/23, .pain was stated to be 8/10. pain locations are LLE (left lower extremity) .surgical incision on front LLE . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/23 (three days after admission), Licensed Practical Nurse (LPN) 'L' (former wound care coordinator) documented, Resident was seen for skin assessment .Wound to LLE with raised area measuring approximately 10 x 12 cm (centimeters). Unable to measure depth. Purulent drainage with slight odor. Resident verbally rates pain 30/10 .Leg was cleansed with Dakins solution and dressed with Silvadene, abd and kerlix . It should be noted that there was no physician's order to cleanse R802's wound with Dakin's solution. On 11/23/23, a Medical Practitioner Progress Note was written by Nurse Practitioner (NP) 'N' that documented, .Open wound is evaluated, slightly malodorous with purulent serosanguineous drainage . On 12/7/23, a General Progress Note documented, .Patient started on ABT (antibiotic) .for 10 days r/t (related to) wound infection to left lower leg . On 12/11/23, a General Progress Note documented, Resident was seen 12/08/23 for weekly rounds .Writer was notified that resident was also seen for post-op by surgeon who gave orders not consistent with that of current wound doctor (Physician 'O'). New puncture sites noted. Writer spoke to resident who decided to follow orders of surgeon. Unit manager, DON (Director of Nursing), and wound doctor notified . It should be noted that Physician 'O' had recommended different orders than the surgeon since he first saw R802 on 11/30/23. There was no documentation that indicated the discrepancy was discussed or clarified. A review of a Consultation Form completed by R802's orthopedic surgeon revealed R802 was seen on 12/7/24. It was documented on the form that R802 was started on an antibiotic for 10 days. The recommended wound treatment was silvadene cream every day. A review of an evaluation conducted by the facility's contracted wound provider, Physician 'O' dated 12/7/24 (the same date R802 was seen by the surgeon), revealed, .Left Lower Leg is a Venous Ulcer .scant amount of serous drainage noted which has no odor .s/s (signs/symptoms) of infection .No . The wound orders documented on the evaluation were .normal saline .xeroform (a non-adherent, occlusive wound dressing that prevents air and moisture loss) .ABD pad .Kerlix . It should be noted that the orthopedic surgeon and Physician 'O' saw R802 on the same day and recommended different treatments and had different assessments of the wound. A review of all evaluations completed by Physician 'O' revealed R802 was first evaluated on 11/30/23 (13 days after R802 was admitted into the facility). R802 was also evaluated on 12/21/23 and 1/4/24 no documentation that he had collaborated with the surgeon. There was no mention of the I&D and the recommended treatments were not the same as what was ordered. A review of R802's Physician's Orders revealed Physician 'O' entered an order on 12/6/23 for xeroform . apply to LLE .every day shift every (Tuesday), (Thursday), (Saturday) for wound care cleanse with wound cleanser, apply xeroform, cover with ABD and Kerlix 3 (times) week and PRN (as needed) . That order remained active until it was discontinued on 12/11/23. A review of R802's December MAR revealed R802 received two different wound treatments (silvadene as recommended by the surgeon and xerofoam as ordered by Physician 'O') on 12/7/23 and 12/9/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation from Physician 'O' to justify a different treatment order than what was recommended from the surgeon or justify receiving two different treatments at the same time. There was no documentation regarding purulent drainage or the wound being malodorous as documented by nursing and the attending provider on multiple occasions since 11/20/23. On 7/30/24 at 10:14 AM, an interview was conducted with the Director of Nursing (DON). When queried about the protocol for managing newly admitted residents' skin , the DON explained the admitting nurse conducted a skin assessment and documented it on the nursing assessment or in the progress note whether there were any open areas or areas of impairment. When queried about how treatment was determined for non-pressure wounds, the DON reported if there were instructions in the hospital discharge summary, you would go off of that. The DON further explained, the facility's wound nurse did a second skin check and ensured the wound treatment orders were correct. The DON reported that Physician 'O' was the facility's contracted wound provider and residents with vascular, diabetic, and pressure wounds were referred to him for consultation. The DON reported she was unsure if he evaluated surgical wounds and was unsure how Physician 'O' collaborated with any specialists involved in the resident's care. When queried about R802, the DON reported R802 did not have a surgical wound and had a vascular wound that was evaluated by Physician 'O'. The DON did not offer an explanation as to why Physician 'O' documented a different treatment than what was ordered. The DON reported R802 did not have an I&D when questioned. When queried about why the special instructions including packing of the wound were not included in the treatment orders upon admission, the DON stated, There was nothing to pack. When queried about where that was documented, the DON referred to LPN 'L's progress note on 11/20/23 that documented, Unable to measure depth. Purulent drainage with slight odor. Resident verbally rates pain 30/10 .Leg was cleansed with Dakins solution and dressed with Silvadene, abd and kerlix . The DON did not provide any further explanation. When queried about why R802 was not seen by Physician 'O' until 10 days after LPN 'L' documented purulent drainage, the DON reported she would look into it. On 7/30/24 at approximately 11:30 AM, the DON followed up and reported the orders from the hospital were not followed because they went off of the MAR and the list of medications and not the special instructions. The DON explained that the special instructions were not clear as to where the wound was. When asked if the admitting nurse should have clarified the order, the DON did not offer a response. When queried about how the nurses doing the treatment would know not to put the medication in the I&D area if it was not specified in the order. At that time, the hospital records were reviewed and the DON reported she did not read all of it and was unaware that R802 had an I&D. When queried about what should have been documented in the admission nursing assessment to indicate any skin impairments as reported in the previous interview, the DON reported the nurse wrote it in the progress note and it documented surgical incision. When queried about the missing treatments and the documentation that they were not done because the nurse did not know where to do the treatment and whether the order should have been clarified, the DON did not offer a response. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Skin Monitoring and Management - Non-PU (Pressure Ulcer), dated 7/11/18, revealed, in part, the following: .The nurse responsible for assessing and evaluating the resident's condition on admission is expected to take the following actions: .Complete an admission assessment/evaluation to identify any non-pressure ulcers existing at that time .Assessment of non-pressure ulcers on admission: .A licensed nurse (which may be the Wound Nurse) must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration , or other unusual findings, must be documented on a comprehensive admission assessment. A licensed nurse .must assess/evaluate each non-pressure ulcer that exists on the resident. This assessment/evaluation should include but not be limited to: .Measuring the non-pressure ulcer .Describing the nature of the non-pressure ulcer (e.g. stasis, surgical wound) .Describing the location of the non-pressure ulcer .Describing the characteristics of the non-pressure ulcer .Once a non-pressure ulcer has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order .All non-pressure ulcer or skin treatments should be documented in the resident's clinical record at the time they are administered .Daily .Ensure all orders have been implemented as ordered .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00145554 Based on observation, interview, and record review, the facility failed to ensure one (R802) of one resident reviewed for foot care, received physician ordered treatment from a podiatrist. Findings include: On 7/29/24 at 11:30 AM, R802 was interviewed in his room. R802 stood for the interview. He was observed to be wearing sandals and his toenails were very long, yellow, and thick. A large, thick, yellow bump was observed on the bottom edge of R802's left foot. R802 reported he needed to see a foot doctor and did not understand why it had not happened yet. R802 reported his toenails got stuck on things due to the length and it was very painful. R802 pointed out the large, raised area on the bottom of his foot and said it was painful. R802 took off one of his sandals to exposed the raised area on the bottom of his foot. He had difficulty putting the sandal back on due to the length of this toenails. Review of an After Visit Summary provided by the hospital to the facility upon admission revealed, .Patient Instructions .Special Instructions: .Please follow up with a podiatrist for you <sic> toes as needed .Follow-Up & future appointments .Schedule an appointment with (podiatrist) as soon as possible for a visit . Review of a Consult Note completed by podiatry (foot doctor) in the hospital on 11/14/23 revealed, .Reason for Consultation/Indication: Elongated, mycotic (fungus) toenails .Chief Complaint: Painful fungal nails . Podiatry was consulted for bilateral elongated, painful mycotic toenails. Patient states that he has not debrided his nails in a while and they are painful on ambulation .toenails x 10 were sharply debrided . A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: peripheral vascular disease (PVD) and onychomycosis (fungal infection of the nail). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had intact cognition and frequent pain. A review of a Medical Practitioner H&P (History and Physician) dated 11/20/23 noted, . ASSESSMENT/PLANS: .Onychomycosis (fungal infection of the nail). Podiatry consult . A review of a Medical Practitioner Progress Note dated 12/6/23 noted, .Following for complaint of .elongated dry toenails .Assured patient he will be in the list for podiatry to see in the next visit .ASSESSMENT/PLANS: Foot care. Consult podiatry, refused lotion . A review of a Medical Practitioner Progress Note dated 1/5/24 noted, .ASSESSMENT/PLANS: .podiatry eval for foot .consult podiatry, refused lotion . A review of a Medical Practitioner Progress Note dated 2/21/24 noted, .Podiatry was re-consulted for nail debridement . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Bloomfield Hills	2975 N Adams Road Bloomfield Hills, MI 48304

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Medical Practitioner Progress Note dated 3/20/24 noted, .podiatry re-consulted for nail debridement . A review of a Medical Practitioner Progress Note dated 3/23/24 noted, .podiatry follows . A review of a Medical Practitioner Progress Note dated 7/18/24 noted, .Pt (patient) has onychomycosis and hypertrophic (thickened) toe nails, needs to follow up with podiatry . A review of R802's physician's orders revealed the following: An active order dated 7/10/24 for Podiatry services consult and treatment for nail debridement one time only for nail debridement for 30 days. An active order dated 11/17/23 for Podiatry services consult and treatment as needed. An active order dated 12/6/23 for Podiatry consult re: foot care. An order with a start date of 1/10/24 and an end date of 2/9/24 for Podiatry services consult for nail debridement one time only for nail debridement for 30 days. An order with a start date of 2/14/24 and an end date of 3/15/24 for Podiatry services consult and treatment: for nail debridement one time only for nail debridement for 30 days. An order with a start date of 6/5/24 and an end date of 7/5/24 for Podiatry services consult and treatment for nail debridement one time only for bilateral toe nail debridement for 30 Days. A review of R802's full clinical record revealed no evidence that R802 was seen by a podiatrist since his admission on 11/27/23. On 7/29/24 at 1:19 PM, an interview was conducted with Social Services Director (SSD) 'A'. When queried about whether R802 had an appointment for a podiatry consult currently or in the past, SSD 'A' reported R802 did not want to sign the consent, but did want to be seen by a podiatrist. There was no documentation of attempts made, follow up with the medical providers, or documentation of R802's refusal of that service. On 7/29/24 at 2:24 PM, an interview was conducted with the Director of Nursing (DON). When queried about who was responsible to schedule physician ordered podiatry consultations, the DON reported the social services department was responsible. When queried about why R802 did not see a podiatrist since his admission despite multiple physician's orders, the DON reported R802 refused to sign a consent. At that time, any documentation of R802's refusal for podiatry care was requested. The DON followed up and said it was documented in a progress note on 11/22/23 that R802 refused podiatry. A review of a Care Plan Progress Note documented on 11/22/23 R802 provided verbal consent for ancillary services, declined to sign that paperwork . When queried about whether the risk and benefits were discussed with R802 or the root cause of why he would only give verbal consent was identified, the DON did not offer a response. When queried about whether the resident should have been approached for consent with each physician's order, the DON did not offer a response. The DON reported the Administrator was responsible for overseeing the social services department. (continued on next page)

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 2:46 PM, an interview was conducted with the Administrator. When queried about whether he was aware that R802 had current active orders for a podiatry consult and multiple orders that were not followed, the Administrator said R802 refused to sign a consent because he was afraid he would owe money. There was no documentation that R802 refused podiatry care and any steps to ensure R802 knew his financial responsibility. On 7/30/24 at 10:45 AM, R802 was further interviewed. When queried about signing a consent for podiatry services, R802 reported when he first got to the facility, they did not explain the process to him and that he was only recently told that the podiatrist would come to the facility to see him. R802 reported he wanted to see the podiatrist and did not understand what was taking so long to see him. R802 reported he told the facility he wanted to see the podiatrist, but he was not comfortable signing the form because he was not sure if he would be charged. R802 further reported that he was presented with the form when he first got to the facility and now it was difficult to walk and it was painful due to his long toenails. On 7/30/24 at 4:36 PM, the Administrator was asked to provide a facility policy regarding podiatry and foot care. The Administrator reported the facility did not have a policy.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI000145412, MI00145592. Based on observation, interview, and record review, the facility failed to provide medically related social services related to competency evaluation, guardianship, discharge planning, and coordinating ancillary services for two (R802 and R804) of three residents reviewed for social services. Findings include: A review of a complaint submitted to the State Agency revealed allegations that included concerns with guardianship and medical issues not being addressed. It was alleged that R802, who was a Veteran, made complaints to the facility social worker who did not follow up or resolve his concerns. A review of a second complaint submitted to the State Agency revealed an allegation that the facility did not allow R804's legal guardian to sign a do not resuscitate order for the resident. R802 (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at approximately 11:30 AM, R802 was interviewed. R802 answered questions appropriately, despite some tangential thinking (thinking/thoughts that do not pertain to original discussion) and statements regarding various conspiracy beliefs, R802 was easily redirectable to the topic being discussed and appeared to understand the questions and answered appropriately and consistently throughout the interview. Without prompting, R802 reporting feeling he was being held against his will at the facility and that the social worker kept telling him he had a guardian, but he had never been provided with any information that verified he had a guardian and he did not believe he had one. R802 reported that his medical provider has only spent minutes here and there with him and he could never get in contact with SS 'J'. R802 explained on 12/30/23, after attempting to contact SS 'J' without success, he contacted a ride share company to take him to his storage unit as he wanted to check on it after being evicted from his apartment and having concerns about his belongings. He had some clothing and other items that he wanted to bring back. R802 further reported that there were emergency vehicles outside of the facility and he was not sure if they were there for another resident. R802 said he had some of his belonging packed up on his wheelchair, but he did plan on returning to the facility after he went to the storage unit. Staff asked him where he was going and he told them to the storage unit. R802 reported he tried to make arrangements with SS 'J' but never heard back. Staff told him that he could not leave the facility without permission from his doctor and guardian. R802 said he did not have a guardian and walked out of the building because his ride was going to be there. According to R802, the police were coming in and staff were trying to talk to them on the side and staff told them R802 was not in any shape to leave. R802 explained that he was aware of his medical issues (wound on his leg after having surgery) but he was afraid of losing his property. When queried about whether he ever went to court regarding guardianship, R802 reported he did not and never received any paperwork regarding a hearing or guardianship. R802 reported he requested guardianship papers from the current social services director (SSD 'A'), but he was not presented with anything. R802 reported that he had no idea he would be stopped from leaving that day. R802 further reported that staff told him that if he tried to leave the facility, they would take him to jail. R802's toenails were observed to be very long, thick, and yellow and there was a thick, dry, yellowish colored bump on the bottom side of R802's left foot. R802 reported he needed to see a foot doctor, but had not yet seen one. R802 reported the facility wanted him to sign a form when he got here and he did not want to sign it but wants to see the foot doctor. R802 reported it had not been readdressed since then and he was experiencing pain due to the long toenails. A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: peripheral vascular disease (PVD) and history of traumatic brain injury. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had intact cognition, no delusions or hallucinations, and no behaviors. Further review of R802's progress notes revealed the following: On 11/8/23, it was documented in a General Progress Note that R802 was A&O x 4 (alert and oriented to person, place, time, and situation), able to make needs known . On 11/20/23, it was documented in a Medical Practitioner H&P (History and Physical) that R802 was homeless, pleasant, and calm. On 11/21/23, it was documented in a Medical Practitioner Progress Note that R802 was alert and oriented x 4. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/23, the following was documented in a Care Plan Progress Note, .met with resident at bedside for care conference .Resident provided verbal consent for ancillary services, declined to sign that paperwork . Resident desires to d/c (discharge) to community upon completion of therapy, however, is homeless. Resident reportedly was evicted from APT (apartment) .d/t (due to) non-payment prior to hospitalization . Resident denied having any supports in the community. Resident hyperverbal, tangential, paranoid, delusional, required frequent redirection during meeting. Difficult to decipher which info is accurate d/t delusions and paranoia. Will have psych evaluate .Will also refer to senior placement agency with resident's consent .Resident has no DPOA (Durable Power of Attorney) or guardian in place. Based on future tx (treatment) and s/sx (signs and symptoms) of psychosis, may need court-appointed guardian. Resident AOx4, although insight and judgement are impaired, some confusion noted .apparent mental illness despite no dx (diagnosis) listed in hospital paperwork . There was no mention of R802's Veteran status and what was done to verify if he had benefits through the local Veterans Administration. On 11/30/23, R802 was evaluated by the facility's contracted behavioral health agency. The following was documented by the psychiatric Nurse Practitioner (NP 'Q'): .Behavioral log reviewed since admission; one episode of abusive language .progress notes reviewed since admission; no issues .Oriented x 3 but insight and judgement appear impaired. He has multiple complaints about the hospital and current facility .He admits to feeling down and anxious but said, 'I just deal with it'. He declined medications. He is frustrated and very irritated. Also hyperverbal and tangential. Denies hallucinations. No delusions expressed .Thought process: organized with redirection .No delusions, paranoia, or hallucinations .Diagnosis and Findings . Adjustment Disorder with mixed anxiety and depressed mood .Resident presents as frustrated and upset regarding his situation/circumstances. He endorses some situational anxiety and depression however he is strongly against the use of psychotropic medication .Other specified disorders of adult personality and behavior .Plan: Pt with Cluster B traits (certain traits associated with specific personality disorders that could include emotional dysregulation, dramatic or attention seeking behavior, hypersensitivity, impulsivity, and/or unpredictability). He is currently homeless and has no family or guardian in place. Refer for competency evaluation. Strict limit setting . (It should be noted that R802 did not receive a competency evaluation until 3/5/24, three months after being evaluated by the psychiatric NP recommended it. On 12/12/23, R802 was seen by a psychologist though the facility's contracted behavioral health agency (Psychologist 'R'). The following was documented in a Behavioral Care Services Progress Note, .was cooperative though again tangential and hyperverbal. He was difficult to redirect and spoke on his various 'injustices' at the facility, prior facilities, and hospitals. He admits to 'bad mood' though denied feeling depressed .No evidence of psychosis. Continued support as needed. He would benefit from the support of a concerned other to assist with decisions regarding treatment, housing, and finances . (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/22/23, a Medical Practitioner Progress Note noted, Following to eval for discharge planning. Patient signify intent to be discharged to a homeless shelter, extensive discussion on safety and discharge regarding homeless shelter discussed with patient as patient is currently on treatment for left lower leg cellulitis, also patient will need psychiatric eval for determination of capacity to make sound medical decision .Currently patient will be unstable to be discharged secondary to ongoing left leg cellulitis and treatment. Patient would need guardian to determine capacity to make sound medical decision. Social worker aware . It should be noted that there was no documentation prior to that note that R802's discharge plan had been further discussed after the care conference on 11/22/23, including the referral to senior placement agency. At this time, R802 had not yet been evaluated for competency, as recommended by the psychiatric NP on 11/30/24. The contracted psychologist did document on 12/12/23 that R802 would benefit from support to assist with decision making, but did not document need for legal guardian or that R802 was incompetent to make any decisions. On 12/27/23, it was documented by R802's medical provider that social work was involved and resident was in need of a guardian to determine capacity to make sound medial decisions. A review of R802's progress notes revealed a General Progress Note dated 12/30/23 that read, Writer came out of a patient's room and saw that the patient (R802) was loading his wheelchair up with his personal belongings. Writer asked the patient where was he going and he stated that he was going to his storage unit. Writer asked patient why was he leaving, patient responded stating he was leaving cause <sic> he had things to handle. patient stated he was not going to stay here due to him having to get to his storage. Writer told patient that we would have to contact his (physician), writer (resident?) said he did not care cause <sic> his ride was on the way. Patient proceeded to leave the unit, writer used cell phone to call (Nurse Practitioner - NP 'N'), to advise that patient was leaving AMA (against medical advice). NP states that patient can not leave due to him being deemed incapable of keeping himself safe. NP states that if patient continues to leave, call police. Writer followed patient to the front and as staff was coming in patient was able to get out the building. Staff attempted to get patient back into the building but patient refused. Writer called 911 for assistance. 911 was able to get patient back into the building but patient states he needs to leave. Patient states he has to get to his storage unit and if he can not leave it will be problems for staff. Police asked patient where he will live and patient unable to answer stating he is going to his storage unit. 911 called NP back and asked for orders to keep patient, unable to give. NP states that if patient leave to call 911 and have him set to hospital for psych hold. 911 was able to convince patient to stay in facility until after NP MD sees him. Patient was advised that if he attempts to leave later then facility will be putting him on a psych hold (involuntary) via ER (emergency room) .Unit Manager, DON (Director of Nursing), Weekend supervisor aware of situation . It should be noted that a competency evaluation for R802 had not been completed at the time of that incident and R802 did not have a legal guardian. On 1/8/24, a Social Services progress note documented R802 was given notification that his insurance benefits were ending and the appeal process was discussed. It was documented R802 has been deemed incapacitated by psychologist and secondary physician, and needs legal guardian to be appointed prior to discharge. Resident displays impaired insight and judgement, no safe discharge plan in place. Plan for SW to petition for court-appointed guardian, resident has no supports or emergency contacts in place . As of this date, there was no evidence of a competency evaluation as verified by SSD 'A'. There were no additional social services notes in R802's clinical record after 1/8/24. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/24, R802 was seen by NP 'Q'. The following was noted, .Oriented x 3 but insight and judgement appear impaired. He said he doesn't need to talk to anyone from psych. He was resistant to conversation. He said his mood is fine and declined medications. He is frustrated and very irritated. Also hyperverbal and tangential. Denies hallucinations. No delusions expressed .Perceptual disturbances are denied and delusional material is not evident . On 3/5/24, R802 was seen by Psychologist 'R'. The following was noted, .cooperative and able to participate in this session. He remains hyperverbal and tangential. Though he remains oriented to reality with facility (cognitive decision making assessment) suggesting intact cognition, he continues to express delusional thinking. Today, he was focused on a storage unit in Detroit, space stations using cell phones to spy on people, chemical warfare and Jesus' role in the 'end of times'. He continues to repeat himself without apparent awareness suggesting impaired short term memory .He would continue to benefit from the support of a concerned other to assist with decisions regarding treatment, housing, and finances .Psychotic Disorder (rule out) . On that date, Psychologist 'R' signed a document titled, Determination of Inability to Participate in Complex Decision Making and indicated R802 was unable to participate in medical treatment and/or financial decisions. Further review of the Determination of Inability to Participate in Complex Decision Making revealed a physician (name illegible) indicated on 3/12/24 that R802 was unable to participate in medical treatment and/or financial decisions. Further review of R802's progress notes revealed no documented competency evaluation by a physician. On 3/20/24, NP 'Q' documented R802 was upset because he was at the facility and reported he would contact a lawyer because he was kept against his will. NP 'Q' documented R802 expressed delusions. On 4/2/24, Psychologist 'R' documented R802 apparently was appointed a guardian recently though this writer could not find documentation of same in his chart. On 5/31/24, it was noted in a Medical Practitioner Progress Note that he was distressed due to medical professionals stripping him of his financial freedom. On 6/28/24, it was noted in a General Progress Note that R802 used profanity toward staff. On 7/8/24, it was noted that R802 called the police regarding the incident that occurred in December (on 12/30/23, R802 was stopped from going to his storage unit). On 7/17/24, it was noted by NP 'Q' that R802 was fixated on events that occurred in December when he thought he could leave the facility. He started cursing about being 'held hostage' at the facility. Continues with accusations towards staff and irritation with processes at that facility . On 7/23/24, it was noted by Psychologist 'R' that R802 would continue to benefit from the support of a concerned other to assist with decisions regarding treatment, housing and finances. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 1:19 PM, an interview was conducted with SSD 'A'. SSD 'A' reported she began working in the facility in May 2024 and was familiar with R802. When queried about whether R802 had a legal guardian, SSD 'A' reported he did not. SSD 'A' reviewed R802's clinical record and reported R802 was deemed incompetent to make decisions on 3/5/24, but did not have guardianship in place. When queried about whether a resident who was not deemed incompetent and did not have a legal guardian had the right to leave the facility, SSD 'A' reported they did have the right. SSD 'A' did not work in the facility on 12/30/23 when R802 wanted to go to the storage unit. SSD 'A' reviewed emails and reported on 7/26/24, a petition was sent to the court for guardianship of R802. It should be noted that the possibility of needing a guardian was first documented on 11/22/23, eight months before the petition was sent to the court. SSD 'A' reported she tried to get consent for a podiatry consult for R802 but he refused. There was no documentation regarding any communication with R802 by SSD 'A'. When queried about whether R802 had Veterans benefits, SSD 'A' reported she did not know. There was no evidence as of 7/29/24 that R802 had been given any housing resources or assistance to plan for a safer discharge other than a homeless shelter (guardianship was being pursued due to R802 wanting to be discharged to a homeless shelter where he resided prior to being admitted into the facility). On 7/29/24 at 2:46 PM, an interview was conducted with the Administrator. The Administrator reported that if a person did not have a guardian and they were deemed incapable of making their own decisions, the facility would petition for guardianship if there were no interested parties. When queried about the timeframe that petition should be submitted from the time that a resident was deemed incompetent, the Administrator stated, Within a reasonable amount of time. When queried about whether R802 had a legal guardian, the Administrator reported he did not. When queried about who was responsible to ensure R802 saw the podiatrist, the Administrator reported R802 refused to sign the consent form because he had concerns about the cost. There was no documentation that R802 refused podiatry care since the care conference on 11/22/23 where he gave verbal consent but refused to sign the consent form. On 7/29/24 at 3:40 PM, an interview with NP 'N' was conducted over the telephone. When queried about why she told the nurse on 12/30/23 that R802 was not allowed to leave the building and if he attempted he would be put on a psychiatric hold, NP 'N' reported she did not really remember, but she would have gone off of what was told to her by the social worker. NP 'N' said R802 seems with it when you talk to him, but doesn't have full insight into his medical situation. NP 'N' further said R802 was very unhappy and did not want to be at the facility. NP 'N' was not aware that R802 was not deemed incompetent on 12/30/23 and did not have a legal guardian. NP 'N' did not know whether R802 had a legal guardian as of 7/29/24. On 7/30/24 at 3:06 PM, an interview was conducted via the telephone with Social Services Staff (SS 'J') who currently worked contingently in the facility. SS 'J' reported she was familiar with R802. When queried about the progress note that documented R802 was deemed incompetent on 1/8/24 when he was not until 3/5/24, SS 'J' reported she did not remember, but that a petition was submitted for guardianship months ago. It should be noted that there was no evidence in the clinical record that guardianship had been pursued prior to SSD 'A's verbal confirmation that the court was petitioned on 7/26/24. A review of a Petition for Appointment of Guardian of Incapacitated Individual revealed SSD 'A' completed the form on 7/26/24. It was documented on the form that R802 was not eligible to receive Veterans benefits, however, SSD 'A' had confirmed that she was unaware of R802's Veteran status and had not verified eligibility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R802's clinical record revealed multiple physician's orders for podiatry consults and treatments and no evidence that he had ever had a consult. R804 A review of R804's clinical record revealed R804 was originally admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on 5/11/24 with diagnoses that included: lupus, dementia, and paranoid schizophrenia. A review of a significant change Minimum Data Set (MDS) assessment dated [DATE] revealed R804 signed onto hospice services, had severely impaired cognition, and clear speech. A review of R804's progress notes revealed the following: On 2/27/24, R804 was transferred to the hospital for evaluation of altered mental status. On 3/6/24, it was documented in a Social Services progress note that R804 was readmitted into the facility. R804 was readmitted on hospice status, signed on by a family member and prior to readmission to the hospital was not interested in becoming guardian. R804 did not have any advance directives in place or a legal guardian. It was documented that Resident will remain Full Code status until legal decision maker is in place. If resident remains in facility until legal guardian in place, POC (plan of care) will be reviewed/revised as appropriate at that time On 3/7/24, it was documented that social services submitted paperwork to attorney office applying for legal guardian to be appointed. On 3/8/24, the following was documented in a General Progress Note that R804 had a change in condition (abnormal vital signs, expiratory wheezing). The doctor was notified and ordered to send to hospital, but when the ambulance arrived her vitals were stable and they refused to transfer her to the hospital. R802's daughter was to come to the facility that day to sign Do-Not-Resuscitate paperwork and it was determined by the family not to send R804 to the hospital. On 5/11/24 at 7:18 AM, it was documented in a nursing progress note that R804 was unresponsive .has shallow breathing .(Cheyne-Stokes) present (abnormal breathing pattern). Resident is in the end stage of the dying process. Hospice on call service notified also family notified of residents condition. On 5/11/24 at 8:18 AM, the following was documented in a nursing progress note, .resident observed by writer having labored breathing .alert and responsive to sternum rub but unresponsive to verbal command. supplement oxygen administered .orders were to transfer resident to hospital. 911 called. resident transferred to hospital at 08:18 (AM) . A review of an Order Regarding Appointment of Guardian of Incapacitated Individual) revealed R804's family member was granted full guardianship of R804 on 4/10/24 and the temporary guardian was discharged from the case. A review of R804's hospice documentation indicated R804 was Do Not Resuscitate .Comfort Measures Only . (continued on next page)

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 3:06 PM, an interview was conducted via the telephone with SS 'J'. When queried about the facility's process if a resident came back from the hospital on hospice and DNR but did not have a legal guardian or legal decision maker in place, SS 'J' reported the facility would not be able to change the code status until there was a legal guardian in place. When queried about why R804's code status was not revisited after R804's family member took the steps to get legal guardianship, SS 'J' reported that in the past R804 had a court appointed temporary guardian that talked to her and she (R804) made it very clear that she did not want to be a DNR. When queried about where that would be documented, SS 'J' reported she did not know. On 7/30/24 at approximately 3:30 PM, the Administrator and SSD 'A' were interviewed. They were unable to find any documentation that indicated R804 had expressed her medical treatment wishes at end of life prior to becoming incapacitated. The Administrator followed up and reported he called the temporary guardian who would send evidence of that conversation. Nothing additional was provided by the facility prior to the end of the survey. A review of the facility's Social Services Director Job Description revealed, .The Social Services Director is responsible to provide medically related social work services so that each Resident may attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. This position assesses and treats emotional and behavioral problems related to patient illness Principal Duties and Responsibilities: . Assess and evaluates each Resident's psychosocial needs and develops goals for providing the necessary services .Assists the residents in adjusting to the facility and promotes a positive environment .Assists resident and families to utilize the community resources when not provided directly by the facility .Ensures completion of any required component of DPOA or guardianship paperwork .Coordinates services with psychiatric providers .serves as an advocate for Resident Rights .Promotes and Protects Resident Rights by assisting Resident to make informed decisions, treating residents with dignity and respect .and supporting independent expression, choice and decision making consistent with applicable laws and regulations .