STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235225	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View of Monroe	1971 N Monroe Street Monroe, MI 48162

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI100145407. Based on interview and record review, the facility failed to ensure dignified and respectful treatment for three residents (R3, R5, and R69) of 28 residents reviewed for dignity, resulting in residents verbalization of feelings of helplessness, frustration, and discontentment when staff respond rudely when answering the call lights, repeatedly talk on their phones during care while ignoring the residents, and sit in resident's rooms when the resident is not present. Findings include: R3: On 9/10/24 at 9:40 AM, R3 said they felt ignored and disrespected by staff because, The CNAs (certified nursing assistants) sit on that [NAME] (sofa) right there (resident pointed to a sofa in the hallway) and play on their phones. They don't even hide it anymore. They just sit there ignoring us while they are on their phones. I came into my room the other day and a CNA was sitting on my chair on her phone. I was so upset. I told the manager about it, but nothing was done about it. R3 went on to say that this occurs regularly on the PM shift from the same staff members. R3 said this has been brought up in resident council meetings several times and nothing has changed. According to R3's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] and had no cognition impairment. The Minimum Data Set (MDS) dated [DATE] indicated that R3 had bilateral upper extremity impairment and needed assistance with all Activities of Daily Living (ADL). R5: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 9:26 AM, R5 said approximately two weeks ago when returning to their room from an activity the resident found two CNAs sitting on the resident's bed looking at their phones. R5 said, I was very upset they were in my room when I wasn't there. They were both sitting on my bed. I asked them why they were in there and they said they had to find their friend and were on facebook trying to figure out where their friend was. R5 said, They sit there and talk to each other in my presence in my room even when they are giving me a bath. I don't want to hear about their personal lives. They don't even include me in the conversation. It's like I'm not even there. It's awful feeling like that. R5 said they did not report this to the manager at this time because they felt helpless because nothing had been done to stop this from earlier complaints. R5 also said that the same two CNAs often sit on the sofa in the hallway and talk to each other or look on their phones instead of checking in on the residents. According to R5's EHR the resident has resided in the facility since 5/20/19 and had no cognition impairment. The MDS dated [DATE] indicated that R5 required assistance for all ADLs. R69: On 9/11/24 at 11:40 AM, R69 said, Some of the CNAs on the afternoon shift are disrespectful and condescending. They either ignore us because they are on the phone the whole time or talk to us like we are two years old. R69 went on to say, When they answer the call lights they say 'What do you want?' or 'I don't have time for that right now, I'll come back.' then they shut the call light off and never come back. We told the manager several times but feel helpless because nothing changed. What can we do? We are at their mercy. R69 said, One time I was napping and woke up because I heard voices. A CNA was in my room, sitting on my chair on the phone while I was asleep. It upset me. It made me feel like I had no privacy. According to R69's EHR the resident had resided in the facility since 9/1/2023 and had no cognition impairment. The MDS indicated that R69 had impairment to one upper extremity and required assistance with all Activities of Daily Living (ADL). On 9/11/24 at 11:02 AM, nurse manager, Registered Nurse (RN) B was asked about use of cell phones during resident care. RN B said, It is in the employee handbook that they (staff) are not supposed to be on their phones during work hours. They can use their phones during their break, but not during care. RN B said she had never heard that CNAs were in resident's rooms sitting on the resident's beds/chairs. RN B said, That's a concern. We will be having an education on that. On 9/11/24 at approximately 12:00 PM the Director of Nursing (DON) was asked about staff's use of cell phones and said, The staff are educated on that. They know they are not supposed to be on their phones during work hours. It is in the employee handbook and I believe there is a policy as well. The DON was unaware that residents had found staff in their rooms sitting on the resident's furniture without an invitation. The DON said that type of behavior would not be considered appropriate. On 9/12/24 at approximately 11:00 AM staff member D who wished to remain anonymous said that she had witnessed staff members looking at their phones while in a resident's room when the resident was not present. Staff member D said that she had notified a unit manager but nothing was really done about it. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's Telephone, Pager and Electronic Device policy last revised 12/14/2023, reads in part; It is the policy of this facility that, unless specifically designated otherwise, cellular phones . or any other electronic devices are not permitted to be worn or used in any area outside of the designated staff member break room. According to the facility's Resident Rights policy last revised 5/14/2024, reads in part; The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI100145407. Based on interview and record review, the facility failed to act promptly on grievances and concern forms reported in resident council meetings and provide responses and resolutions for two grievances filed in the last four months, as reported during confidential resident council meetings, resulting in unresolved resident concerns, residents expressing feelings of helplessness, and decreased quality of life. Findings include: Review of the Resident Council Meeting (RCM) Minutes, written by Activity Director (AD) C, dated 5/20/24 had the following nursing concerns; Complaints about Certified Nursing Assistant (CNA) E. Complaints about multiple staff in one room at a time. The complaints were not specified. A Resident Assistance Form, completed by AD C from the RCM dated 5/21/24 documented that CNA E was rude and had no bedside etiquette. There were no specific behaviors identified. The Facility Response section indicated that the staff member (CNA E) was educated. There was no specific education identified. Review of the RCM Minutes, written by AD C, dated 6/23/24 had the following nursing concerns; Complaints about multiple CNAs, including CNA E for repeatedly talking about their personal life and being on their cell phones during care, and something else that is whited out and unable to be seen. A Resident Assistance Form written by AD C, from the RCM dated 6/23/24 documented the following concerns; CNA E rude to residents. CNA E stated to a resident We are really busy, Let's get this over with, and What do you need now? The Facility Response section indicated that a manager would talk with staff member (CNA E) and the residents to ensure correct information. There was no additional follow-up documentation. Review of the RCM Minutes written by AD C for both 7/22/24 and 8/26/24 had no Old Business that listed follow-up from the last months minutes. There was no documentation to indicate the previous concerns from the 5/21/24 or 6/23/24 RCM had been resolved. On 9/12/24 at approximately 11:00 AM AD C was asked about the 'whited out' section on the RCM minutes for 6/23/24 and replied, The residents had complained about CNAs being rude and on their phones in May. The residents brought it up again in June, but then retracted it and did not want me to bring it up again, so I whited it out. AD C acknowledged that multiple residents continued to complain about CNA E at both the May and June RCM. AD C said, I did bring the resident's concerns to the manager and the Administrator. Review of the RCM minutes for both 5/21/24 and 6/23/24 included the Nursing Home Administrator's (NHA) signature. AD C could not say if the resident's concerns had been completly addressed to the resident's satisfaction. AD C could not explain why there were no Old Business notes on the July or August RCM minutes. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3: On 9/10/24 at 9:40 AM, R3 said they felt ignored and helpless because they had brought up concerns with certain staff members in resident council meetings several times and nothing has changed. The CNAs sit on that [NAME] (sofa) right there (resident pointed to a sofa in the hallway) and play on their phones. They don't even hide it anymore. They just sit there ignoring us while they are on their phones. I came into my room the other day and a CNA was sitting on my chair on her phone. I was so upset. I told the manager about it, but nothing was done about it. R3 went on to say that this occurs regularly on the PM shift from the same staff members. According to R3's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] and had no cognition impairment. The Minimum Data Set, dated dated dated [DATE] indicated that R3 had bilateral upper extremity impairment and needed assistance with all Activities of Daily Living (ADL). R5: On 9/10/24 at 9:26 AM, R5 said approximately two weeks ago when returning to their room from an activity the resident found two CNAs sitting on the resident's bed looking at their phones. R5 they did not report this to the manager at this time because they felt helpless because nothing had been done to stop this from their earlier complaints. According to R5's EHR the resident has resided in the facility since 5/20/19 and had no cognition impairment. The MDS dated [DATE] indicated that R5 required assistance for all ADLs. R69: On 9/11/24 at 11:40 AM, R69 said, We told the manager several times about CNAs being on their phone but feel helpless because nothing changed. What can we do? We are at their mercy. According to R69's EHR the resident had resided in the facility since 9/1/2023 and had no cognition impairment. The MDS indicated that R69 had impairment to one upper extremity and required assistance with all Activities of Daily Living (ADL). On 9/12/24 at 11:40 AM nurse manager, Registered Nurse (RN) B and the Director of Nursing (DON) was asked about the RCM minutes form 5/2024 and 6/2024 and said that the CNAs had received training and had write ups for those incidents. RN B said that she was unaware that the cell phone use in resident care areas had continued or that CNAs were in resident's rooms sitting on the resident's beds/chairs. On 9/12/24 at approximately 12:00 PM the Nursing Home Administrator (NHA) was asked to review the RCM minutes from April - August 2024. The NHA acknowledged there was white-out on the concern section for nursing department for June and then no follow-up on the July or August meetings. The NHA said she was aware there were concerns with CNAs and could not explain why there was no documented follow-up on the RCM minutes. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's Resident Rights policy last revised 5/14/2024, read in part; The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility These rights include the resident's right to: Voice grievances and have the facility responds to those grievances. According to the facility's Guest/Resident Council last revised 8/25/21 and effective 6/2/22, read in part: The Guest/Resident council provide a formal, organized means of guest/resident input in to facility operations. Procedure: 10. Minutes of the meeting will be recorded and maintained for at least two years. Minutes will not include residents names in regard to issues and complaints. 11. The Guest/Resident Council grievances and recommendations will be documented on the Guest/Resident Assistance Form The completed forms are brought to the attention of the Administrator who will forward the forms to the respective department head for attention and response. 12. Responses regarding resolution are to be documented on the Guest/Resident Assistance Form, reviewed by the Administrator and a copy of the completed forms are sent to [NAME], and kept with the Guest/Resident council minutes. 13. Action taken and/or considerations given to issues will be reported back to the Guest/Resident Council at the following meeting and documented within the minutes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review, the facility failed to properly date-label food stored in resident refrigerators affecting all the residents who consumed food from the unit refrigerators resulting in unidentifiable resident items and the potential for food-borne illness. Findings include: On 9/11/24 at 8:53 AM unit refrigerators were observed with the Nursing Home Administrator (NHA, the following were noted: Pleasant View Unit -One 16-ounce opened used jar of Betty's dressing expiration date unknown. Evergreen Unit -One box of unlabeled opened [NAME] Dean breakfast sandwiches in freezer. -One box of unlabeled opened ice cream Drumsticks in freezer. -Two 20-ounce bottles of diet mountain dew unlabeled in refrigerator. The NHA agreed all food items should be labeled and dated. Only resident food should be stored in the unit fridges. On 9/12/24 at 9:28 AM the Director of Nursing was interviewed and said that nursing staff are responsible to maintain the unit refrigerators and agreed food items in unit refrigerators should be labeled and dated. Review of the facility policy titled Food from Outside Sources revised 11/12/2021 revealed in part .All food brought in is to be checked by the Nurse, Dietary Manager, or Dietician. It must be placed in a sealed container and labeled for the content, the guest's/resident's name and date the food was received, and an expiration date of 3 days after food was brought in. It is recommended that only enough food be brought in for that visit.