

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Cherry Hill for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  38410 Cherry Hill Rd Westland, MI 48185	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40330</p> <p>Based on interview and record review, the facility failed to answer call lights timely for eight confidential group meeting residents (C1, C2, C3, C4, C5, C6, C7, and C8) of 19 residents reviewed for dignity. Findings include:</p> <p>On 10/23/24 at approximately 11:40 a.m., eight confidential interviewable group residents (C1, C2, C3, C4, C5, C6, C7, C8) reported feeling frustrated and being discouraged as they were waiting more than a half hour for their call light to be answered. Resident C1, reported they had filed grievances with the Activity Director, Staff F, and had made the facility aware of the resident's call light concerns, with limited follow up. Two residents described specific incidents, as follows:</p> <p>C2: Reported they waited 45 minutes for staff to answer their call light a couple weeks ago, at night, when he fell and hurt their shoulder.</p> <p>C3: Reported they sometimes waited an hour and a half to use the bathroom, during the day shift, causing incontinence.</p> <p>Five of the eight residents indicated they waited 45 minutes or more at times for their call lights to be answered, which caused them feelings of discouragement and helplessness, as they needed assistance with care.</p> <p>On 10/24/24 at approximately 11:45 a.m., the Activity Director, Staff F, who was present at the group meeting per residents' invitation, was asked about residents reporting extended call light wait times. Staff F confirmed residents reported longer call wait times in the monthly meetings. Staff F reported they had observed longer wait times in the evenings when they were in the facility working until 7:30 p.m Staff F confirmed sometimes staff were difficult to locate, and they turned in the grievance forms.</p> <p>On 10/24/24 at approximately 1:55 p.m, the resident council group concerns were collectively reviewed with the Director of Nursing (DON) who confirmed they had planned to address the residents' concerns, and would attend the next resident council group meeting.</p> <p>Review of resident council minutes and attached concern forms showed:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7/09/24: One call light concern noted on the minutes and concern form, showing extended call wait times.</p> <p>9/10/24: Six call light concerns noted on the minutes or concern forms, showing five residents and the resident council group reported collective concerns.</p> <p>Further review of the September (2024) concern forms showed residents reported they were unable to locate nursing staff for assistance, their call lights were not being answered, and one resident reported being left soiled. There was follow-up documented on one of the six concern forms; the rest of the forms were blank below the complaints, i.e. in the summary of findings or conclusions sections.</p> <p>Review of the policy, Quality of Life, Dignity, revised April 2009, revealed, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .</p> <p>A policy was requested specific to call light answering, and not received by survey exit on 10/24/24.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330</b></p> <p>Based on observation, interview, and record review, the facility failed to place call light within reach and provide a closet door for two residents (R89 and R84) of four residents reviewed for accommodation of needs. Findings include:</p> <p>R89:</p> <p>On 10/22/24 at 1:11 p.m., R89 was observed laying in their bed, wearing a hospital gown. They were observed leaning to the left side of their bed, resting their head on the enabler bar, which appeared uncomfortable. R89 reported they were in significant pain and wanted pain medication. Further observation revealed their touch pad call light was out of reach, on the right side of the bed on their dresser.</p> <p>On 10/22/24 at 1:15 p.m., R89 was asked if they used their call light. R89 reported they used their call light for pain medication, or if they needed other assistance.</p> <p>On 10/24/24 at 11:44 a.m., R89 was observed sleeping in their hospital bed, leaning against the left enabler bar. R89's call light was on the right side of their bed, on their dresser, out of reach.</p> <p>Review of R89's Minimum Data Set (MDS) assessment, dated 9/18/24, revealed R89 was admitted to the facility on [DATE], with diagnoses including high blood pressure, malnutrition, and depression. R89 required maximal assistance with toileting, moderate assistance with bed mobility, and was dependent for transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed R89 was cognitively intact.</p> <p>On 10/24/24 at 11:46 a.m., Certified Nurse Aide (CNA) G was asked if R89 used their call light, and why it was on their dresser, and showed CNA G the location. CNA G reported R89 used their call light and had asked for a blanket earlier this morning by activating their call light. CNA G responded it must have been removed during care and not replaced. CNA G confirmed the call light was out of R89's reach.</p> <p>On 10/24/24 at 11:47 p.m., Licensed Practical Nurse (LPN) H was asked if R89 used their call light. LPN H confirmed they had used their call light this morning to request pain medication and a cup of milk. LPN H reported the call light should always be in R89's reach as they used it regularly and it must be in their reach.</p> <p>R84:</p> <p>On 10/24/24 at 12:00 p.m., R84's closet (room [ROOM NUMBER]-1) was observed per their request. Their clothes closet was completely open, with no closet door or curtain covering the clothing. R84's clothing and his roommate's clothing were showing, as well as some clear garbage bags and miscellaneous personal items of R84's, which were on the floor of the closet, visible from the doorway. R84 said they had filed a grievance a few months ago reporting this bothered them, as they wanted their room to look neater and have their clothes and personal items covered. R84 reported they had not received adequate follow-up, as their closet door was still opened, and looked bad to them.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Electronic Medical Record (EMR) showed R89 was admitted to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R84 was cognitively intact.</p> <p>Review of July's grievance forms, provided by the Director of Nursing (DON) on 10/23/24, revealed a grievance form dated 7/10/24. The grievance showed: No closet doors. We [residents] pay too much for doors to not work. There was no response at the bottom of the form or attached.</p> <p>On 10/24/24 at 1:58 p.m., the DON, was asked about R89's call light being out of reach on two occasions. The DON confirmed the call light should always be on R89 and must have been removed during cares. The DON noted the call light could be clipped to R89 to prevent it from sliding off. Environmental concerns including R84's concerns were shared with the DON, who confirmed they would be addressed.</p> <p>A policy was requested related to accommodation of needs and call lights and was not received by survey exit on 10/24/24.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>40330</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate space and privacy for resident counsel group meetings for 19 of 19 residents reviewed for organized group meetings. Findings include:</p> <p>On 10/23/24 at approximately 11:20 a.m., 19 residents were observed in the activity room, with the Activity Director, Staff F present. Residents were observed crowded into this smaller room, with some seated only one to three feet apart. There were frequent knocks at the closed door, either by staff or residents. A few residents arrived later, or left, and had difficulty negotiating room entry or exit around the residents who were seated in wheelchairs.</p> <p>On 10/23/24 at 11:31 a.m., the group meeting participants collectively reported feelings of frustration and privacy concerns meeting in the activity room at the facility. Two residents reported they and the residents preferred to meet in the large facility dining room, however there were too many interruptions by staff coming in and out of the space, no matter what time they held the meeting. Staff F said they tried to meet in the dining room in the past a few times, and they had to return to the activity room to meet due to the staff interruptions. Residents collectively reported feelings of frustration, as they wanted to meet privately and would be most comfortable in a larger space, like the dining room.</p> <p>During an interview on 10/24/24 at 1:43 p.m., the Director of Nursing (DON) was asked about the limited space available for the monthly Resident Council meeting, with resident's reporting in the group meeting they were frustrated with the small space of the activity room and were interrupted in the larger dining room when they had attempted to meet there in the past. The DON stated, I am agreeable for them to being in the dining room [to meet for Resident Council meetings], and they should be able to be [meet] non-interrupted and have that time and space for an hour. The DON reported they were familiar with the activity room where residents met for their monthly meetings, and acknowledged this was a small space for the number of residents who attended the monthly resident council meetings.</p> <p>Review of the policy, Quality of Life - Homelike Environment, revised May 2017, revealed, Residents are provided with a safe, clean, comfortable and homelike environment .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32220</p> <p>Based on observation, interview and record review the facility failed to ensure medications were labeled and dated when opened and or discarded when expired in two of four medication carts and one supply room reviewed. Findings include:</p> <p>On [DATE] at 9:09 AM a check of the medications in medication cart three with Licensed Practical Nurse (LPN) I revealed: A Breo Ellipta inhaler was not dated on the actual inhaler; A Humalog insulin vial with open date of [DATE] was expired; A Lantanoprost eye drops vial dated ,d+[DATE] on the box was not dated on the vial; a brimonidine eye drop was not dated when opened on the vial or the box; a second Latanoprost eye drop was not dated when opened on the vial or box; and a Dorzolomide eye drop was not dated when opened on the vial.</p> <p>On [DATE] 9:36 AM, a review of the number four medication cart with LPN J revealed: the glucose strips not dated when opened, an Ademolog insulin was dated ,d+[DATE] on the box but not on the vial, a novolog insulin had an expired dated of [DATE] and a second vial of novolog insulin had an expired date of , d+[DATE].</p> <p>On [DATE] at 9:00 AM, an observation of the supply room with LPN A revealed six max protein shakes which expired [DATE].</p> <p>On [DATE] at 11:06 AM, the Director of Nursing (DON) reported the nurse should check the medication carts they are on.</p> <p>A review of the facility policy titled Storage of Medications dated [DATE] revealed Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>Policy Interpretation and Implementation 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.</p> <p>3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated .</p> <p>A review of the prescribing information at drugs.com revealed, .Safely throw away Breo Ellipta in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler and the Novolog vial when opened is good for .28 days (refrigerated/room temperature) The Manufacturer's web site for Ademlog insulin documented .Must be used within 28 days after first use .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>40330</p> <p>This citation relates to Intake #MI00146436.</p> <p>Based on observation, interview, and record review, the facility failed to provide palatable, appetizing meals at the proper temperature for 19 of 19 confidential group meeting residents. Findings include:</p> <p>On 10/23/24 at 11:31 a.m., residents collectively shared concerns related to the meals at the facility which had been occurring over the past few months, and possibly longer. The resident council President and [NAME] President were in attendance, as well as the Activity Director, Staff F, per their request. Residents collectively shared their concerns as follows:</p> <ol style="list-style-type: none"> <li>1. They wanted hot meals at mealtimes, and reported the trays were frequently not served from the meal carts anywhere from 15 minutes to 45 minutes.</li> <li>2. The meals tasted bland and were not appetizing, as they had no flavor.</li> <li>3. They wanted more variety of the menu, and said they had the same foods most weeks.</li> <li>4. They did not like the Tilapia fish, and several residents said, It tastes nasty.</li> <li>5. They reported they were told there was no budget for any extra preferences.</li> <li>6. Most did not want sandwiches for dinner, and reported the sandwiches did not have lettuce, tomato, and oftentimes cheese, and only one slice of meat.</li> <li>7. They would like to have a food committee, as they did in the past and they did not know why it was cancelled.</li> <li>8. They reported receiving too much pork and hot dogs.</li> <li>9. They reported their food was sometimes wet, from condensation from the food sitting on the trays and older food covers, which made the food wet and soggy.</li> <li>10. They had asked for dietary staff to be present at their resident council meetings to hear their food concerns, which had not occurred.</li> </ol> <p>On 10/23/24 at 1:32 p.m., during an observation of a lunch meal tray, the following entree was observed, a chicken and biscuit entree and green beans. The chicken appeared wet at the base, from condensation on the plate. There was condensation on the tray under the beverages, inside the plate lid, on the tray below the plate, and on the plate itself. Further observation revealed the hard plastic plate cover appeared worn, with jagged, worn edges, which prevented the lid from fully sealing against the plate.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident council minutes for July, 2024, August, 2024, and September, 2024 showed no kitchen or dietary staff attended the meetings.</p> <p>Review of the resident council minutes, dated 9/2024, showed residents reported they were receiving wet sweaty food from food condensation from sitting in the plate cover too long. Residents reported the cups, plates, utensils, and plate lids were sometimes dirty, and requested staff did a better job of washing them.</p> <p>Review of resident council minutes, dated 8/13/24, revealed residents asked for more variety on the menus.</p> <p>Review of the resident council minutes, dated 7/09/24, showed residents wanted less sandwiches and an updated menu.</p> <p>On 10/24/24 at 1:48 p.m., the Director of Nursing (DON) was asked about the collective resident food concerns, and reported they were addressing them, and understood the concerns.</p> <p>Review of the policy, Food preferences, revised 7/2023, revealed, Individual food preferences will be assessed and upon admission and updated as needed. Reasonable efforts will be made to accommodate resident choices and preferences .6. A periodic Food Committee meeting will be held to review issues related to food preferences and meals and try to identify more widespread concerns about meal offerings, food preparation, etc .</p> <p>Review of the policy, Temperatures, revised 7/2023, revealed, .Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperature (i.e. hot/cold carts, pellet systems, insulated plate bases and domes, etc ).</p> <p>Review of the policy, Food and Nutrition Services, revised October 2017, revealed, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional needs and special dietary needs, taking into consideration the preferences of each resident .</p> <p>38207</p> <p>On 10/23/24 at 12:55 PM, a lunch tray was test. The biscuit with chicken, vegetables, and gravy on it was tasted and the chicken tasted processed.</p> <p>On 10/24/24 at 1:03 PM, a lunch tray was tested from a food cart on the two hundred unit and temperature checked. Unidentified staff E who was serving trays out of the food cart, indicated the cart had been sitting on the unit for approximately twenty minutes. The temperature of the food on the tray was the following, marinated mixed vegetable salad: 109 degrees Fahrenheit; and the apple juice was 51 degrees Fahrenheit.</p> <p>On 10/24/24 at 1:20 PM, Dietary Manager (DM) D was interviewed about interventions available for residents regarding food concerns, and if residents were able to obtain fresh fruit. DM D stated, We used to have a food committee, but no one showed up, so we discontinued it. I meet with the residents all of the time. DM D stated, We don't really do fresh fruit unless it is in season. In the summer the residents were served strawberries and we had watermelon.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/24/24 at 1:30 PM, the Administrator (NHA) was interviewed via phone regarding their expectations for the food served to the residents at the facility. The NHA indicated the food served to residents should be at the appropriate temperature, served timely, and appropriate for the individual's diet.</p> <p>A facility policy titled Temperatures Rev [Review] 7/2023 was reviewed and revealed the following, 1. All hot foods must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 F .2. All cold foods items must be maintained and served at a temperature of 41 F or below.</p> <p>A facility policy titled Resident Food Preferences Rev. 7/2023 was reviewed and revealed the following, Policy Statement: 5. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38207</p> <p>Based on observation, interview, and record review, the facility failed to store an oxygen tank in an safe manner involving one resident (R45) of four residents reviewed for environment. Findings include:</p> <p>On 10/22/24 at 12:44 PM, an observation was made of an oxygen tank without a holder, behind the bed, against the wall in R45's room. R45 was interviewed about the oxygen tank in their room and stated, I don't know, saying the oxygen tank had been in their room ever since admission. R45 denied receiving oxygen therapy.</p> <p>A record review of R45's electronic medical record (EMR) confirmed that R45 did not receive oxygen therapy. Further review of R45's EMR revealed that R45 was originally admitted to the facility on [DATE] with diagnoses that included, Paroxysmal atrial fibrillation (Irregular rapid heartbeat) and Alcohol abuse. R45's most recent minimum data set assessment (MDS) dated [DATE] indicated R45 had an intact cognition.</p> <p>On 10/24/24 at 11:06 AM, Licensed Practical Nurse (LPN) D was interviewed and asked if R45 was receiving oxygen therapy. LPN D stated, [R45] doesn't have an order for oxygen.</p> <p>On 10/24/24 at 11:15 AM, Maintenance Director (MD) C was shown the oxygen tank in R45's room and stated, That shouldn't be there. MD C further indicated all oxygen tanks not in use, should be stored in the facility's oxygen storage room in a holder.</p> <p>On 10/24/24 at 1:30 PM, the Administrator (NHA) was interviewed via phone regarding their expectations for the storage of oxygen tanks. The NHA indicated that oxygen tanks should be stored in a locked area in the appropriate holder.</p> <p>A facility policy titled Small Compressed Oxygen Cylinders dated, 2006 was reviewed and revealed the following, Safety: The safe use of compressed oxygen cylinders requires it to be used as instructed, which includes the following safety precautions .store oxygen cylinders in approved carts or holders .</p>		