STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235236	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burcham Hills Retirement Ctr	2700 Burcham Drive East Lansing, MI 48823

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 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** 38383 This citation pertains to intake MI00149664. Based on interview and record review, the facility failed to 1) assess and monitor respiratory status for one (Resident #3); and 2) administer respiratory medications as ordered for one (Resident #6) of six reviewed. Findings include: Resident #3 (R3): Review of the medical record reflected R3 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia and dependence on supplemental oxygen. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], reflected R3 scored 10 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R3 died in the facility on [DATE]. A Physician's Order, with a start date of [DATE], reflected R3 was to receive oxygen, titrated at a rate of two to five liters per minute, to maintain blood oxygen saturation levels between 88 and 92 percent (%). A Progress Note for [DATE] at 4:45 AM reflected R3's oxygen saturation was 73%, and new oxygen tubing and a new nebulizer kit were provided. R3's vitals signs documentation reflected their oxygen saturation was 83% while receiving oxygen at four liters per minute on [DATE] at 4:45 AM. According to the medical record, there was no follow-up for R3's oxygen saturation levels until [DATE] at 7:38 AM, when it was recorded as 89% while receiving oxygen. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [DATE] Medication Administration Record (MAR) reflected R3 had an order for Ipratropium-Albuterol Inhalation Solution (respiratory medication) 0XXX,d+[DATE].5 (3) milligrams (mg) per 3 milliliters (mL) to be inhaled orally, via nebulizer, every two hours as needed for COPD. The MAR reflected that lung sounds were to be auscultated (listened to/assessed) before treatment, indicated as LSB, and after treatment, indicated as LSA. The nebulizer was administered 57 times during the month of December. Documentation reflected that R3's lung sounds were assessed 17 out of 57 times that the medication was administered. The [DATE] MAR reflected R3's Ipratropium-Albuterol Inhalation Solution every two hours as needed was administered nine times between [DATE] and [DATE]. Lung sounds were not documented as being assessed before or after administration for any of nine the doses. R3's medical record reflected their blood oxygen saturation level was 86% while receiving oxygen, on [DATE] at 7:40 AM. The [DATE] MAR reflected R3 received an as needed Ipratropium-Albuterol Inhalation Solution nebulizer at 8:20 AM, with a recorded blood oxygen saturation level of 86%. The medical record did not reflect that R3's blood oxygen saturation level had increased to 88% to 92%, per their orders, and did not reflect further follow-up until [DATE] at 3:02 PM. On [DATE] at 3:02 PM, R3's blood oxygen saturation level was 80% on room air (without the use of oxygen). On [DATE] at 3:08 PM, R3's blood oxygen saturation level was 82% with oxygen in place. The [DATE] MAR reflected an as needed Ipratropium-Albuterol Inhalation Solution nebulizer was administered on [DATE] at 3:02 PM, with a recorded oxygen saturation level of 80%. The medical record did not reflect that R3's blood oxygen saturation level had increased to 88% to 92%, per their orders, and did not reflect further follow-up until [DATE] at 8:43 PM, when their blood oxygen level was 90% with oxygen in place. On [DATE] at 2:13 PM, R3's blood oxygen saturation level was 86% while receiving oxygen. The [DATE] MAR reflected an as needed Ipratropium-Albuterol Inhalation Solution nebulizer treatment was administered. The medical record did not reflect that R3's blood oxygen saturation level had increased to 88% to 92%, per their orders, and did not reflect further follow-up until [DATE] at 7:27 PM, when their blood oxygen saturation was 88% with oxygen in place. According to the [DATE] MAR, R3 received as needed Ipratropium-Albuterol Inhalation Solution nebulizer treatments on [DATE] at 7:38 AM and 2:10 PM. A Progress Note for [DATE] at 3:43 PM reflected R3 was observed removing their nebulizer right after it was provided, stating they could not breathe and needed another breathing treatment. In an interview on [DATE] at 10:26 AM, Licensed Practical Nurse (LPN) G reported they were unaware of what LSA and LSB meant pertaining to R3's as needed Ipratropium-Albuterol nebulizer order documentation. LPN G reported they did not always remain with R3 when administering their nebulizer treatments. LPN G stated they went back after the nebulizer treatments were complete and disassembled the nebulizer kit. LPN G reported they did not remain with R3 when administering their as needed nebulizer treatment in the morning on [DATE] or in the afternoon of [DATE], despite being aware that R3 removed their nebulizer mask at times, including that day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 12:49 PM, Director of Nursing (DON) B indicated that lung sounds should have been assessed with administration of R3's as needed nebulizer treatments. DON B reported nurses should have remained with R3 when their nebulizer treatments were being administered. DON B reported LSB stood for lung sounds before, and LSA stood for lung sounds after (administration of R3's as needed nebulizer treatment). DON B reported R3 removed their oxygen at times. Regarding the expectation for monitoring and follow-up of blood oxygen saturation levels, DON B reported they would expect the nurses to assess first. If the resident had their oxygen off, they could replace the oxygen and recheck the resident in a few minutes. If they had their oxygen in place but continued to have lower blood oxygen saturation levels, DON B stated the expectation was that the nurse would call the physician. Resident #6 (R6): Review of the medical record reflected R6 admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure with hypoxia, influenza due to identified novel influenza A virus with pneumonia and asthma. The 5-day Medicare MDS, with an ARD of [DATE] reflected R6 scored 15 out of 15 (cognitively intact) on the BIMS. R6 died in the facility on [DATE]. The [DATE] MAR reflected an order for Budesonide Inhalation Suspension (respiratory medication) 0.5 mg per 2 mL to be inhaled orally, twice daily, for asthma. The MAR reflected the medication was not administered in the evening on [DATE], the morning or evening of [DATE], the evening of [DATE] or the morning and evening of [DATE] and [DATE]. R6 received five of their 13 scheduled doses of Budesonide between [DATE] and [DATE]. A Progress Note for [DATE] at 10:26 PM reflected the Budesonide was on order. There was no documentation that the Physician was notified that the dose was not administered. A Progress note for [DATE] at 12:53 PM reflected Budesonide was not available. There was no documentation that the Physician was notified that the dose was not administered. A Progress Note for [DATE] at 10:33 PM reflected Budesonide was n/a. There was no documentation that the Physician was notified that the dose was not administered. A Progress Note for [DATE] at 10:07 PM reflected Budesonide was not available. There was no documentation that the Physician was notified that the dose was not administered. A Progress Note for [DATE] at 10:50 AM reflected Budesonide was not available. There was no documentation that the Physician was notified that the dose was not administered. A Progress Note for [DATE] at 10:33 PM reflected Budesonide was not available. According to the note, the pharmacy was made aware and would ship the medication. There was no documentation that the Physician was notified that the dose was not administered. A Progress Note for [DATE] at 8:35 AM reflected Budesonide was n/a. There was no documentation that the Physician was notified that the dose was not administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note for [DATE] at 7:39 PM reflected Budesonide was not available, and the facility was awaiting shipment. There was no documentation that the Physician was notified that the dose was not administered. In an interview on [DATE] at 12:49 PM, DON B reported if a medication was not in a residents supply, the expectation was for pharmacy to be contacted to see when the medication was expected to be delivered. DON B reported they expected nurses to administer medications that were available in the facility's backup supply. DON B stated their expectation was for the Physician to be notified that R6's respiratory medications were not given, for any reason, for guidance on how to proceed.