STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024

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

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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 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 34705

Based on observation, interview, and record review, the facility failed to provide services that met the acceptable standards of clinical practice for peripherally inserted central catheter (PICC) line dressings in 1 of 1 sampled resident (Resident #543) reviewed for PICC lines, from a total sample of 18 resident, resulting in the increased likelihood for infection.

Findings include:

According to Clinical Nursing Skills & Techniques, 6th edition, ([NAME], A., [NAME], P. 2006. page 937), A transparent dressing should be changed with annual site rotation and immediately if integrity of the dressing is compromised. Gauze dressings should be changed routinely every 48 hours and immediately if integrity is compromised. Gauze used underneath a transparent dressing is considered a gauze dressing and should be changed every 48 hours.

According to the publication American Nurse Today, dated May 2014, volume 9, number 5, under PICC line dressing changes: Change a transparent dressing every 7 days, if the dressing is no longer intact, oozing or has become bloody or contaminated, change it as soon as possible.

Review of the facility, Central lines dressing change, dated 10/19/23, reflected, PURPOSE: To minimize the risk of catheter infection, damage, displacement and other complications by providing a uniform technique for dressing changes. To maintain patency of central venous catheters .Sterile gauze dressings for central lines will be changed every 48 hours. Note: gauze under a transparent dressing is considered a gauze dressing. 5. Transparent dressings on both percutaneous and surgically-placed lines will be changes every 7 days. It is recommended that they be changed within the first 24 hours after insertion when there is accumulation of blood or serosanguinous drainage under dressing. More frequent changes are needed if the dressing is no longer occlusive or if there is drainage under the dressing .

Resident #543(R543)

Review of the Face Sheet dated 5/23/24, reflected R543 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included recent right great toe amputation post osteomyelitis with current Intravenous(IV) antibiotic treatment, hypertensive heart disease with heart failures, diabetes mellitus, and depression.

(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	During an observation and interview on 5/21/24 at 9:39 AM, R543 was sitting up in chair appeared calm and able to answer questions without difficulty. R543 reported concern that during breakfast that morning nurse came in to administer IV antibiotics and reported would return after breakfast but nurse had not yet returned. R543 had a single lumen PICC located in the right upper arm with dressing dated 5/20/24 with gauze observed over insertion site under clear occlusive dressing. R543 right arm appeared visibly swollen compared to left arm. R543 reported was admitted to the hospital for infection in right foot that went to blood and had right toe amputation and was taking IV antibiotics every 24 hours. During an observation and interview on 5/23/24 at 8:18 AM, R543 had right leg elevated on pillow in bed with ace in place. R543 continued to have PICC in right upper are with same clear dressing with gauze over insertion site, with quarter size blood stain, dated 5/20/24. R543 right arm continued to appear visibly swollen compared to left arm. R543 reported right arm continued to itch and staff had not asked about or measured right arm. Review of the Nursing Progress notes, dated 5/20/24 through 5/23/24, with no mention of R543's right arm swelling. During an interview on 5/23/24 at 10:19 AM, Physician N reported was not aware of issues with R543 right arm where PICC was located including increased swelling. Unit Manager (UM) O approached Physician N and reported R543 right arm swelling had been reported to her that day and requested Physician N to assess. During an interview on 5/23/24 at 10:23 AM, Licensed Practical Nurse (LPN) P reported observed R543 right arm for the first time since admission today and reported increased swelling to UM O. LPN P reported if a resident has a PICC in place, nurse staff assess PICC site, and reported unable to see R543 insertion site related to gauze covering site. LPN P reported PICC dressings with gauze over insertion site should be changed within 24 hours and arm measurements taken. During an interview on 5/23/24 at 10:46 AM, Physician N reported R543 was assessed including right upper arm. Physician N reported changed R543 PICC dressing and removed the gauze dressing and reported PICC dressings with gauze over insertion site should be changed within 24 hours to removed gauze. During an observation on 5/23/24 at 11:23 AM, R543 was observed in hall with staff assist with clear occlusive dressing over right upper arm PICC. During an interview on 5/23/24 at 11:34 AM, UM O reported would expect new PICC dressings with gauze to be changed within 48 hours of admission to assess insertion site for signs of infection and reported was unsure why R543 dressing was not changed before 5/23/24. UM O verified R543 had unplanned transfer to the hospital 5/22/24 and returned within few hours related to uncontrolled bleeding from surgical site. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 11:48 AM Director of Nursing (DON) B reported would expect new admission with PICC to have orders followed that included PICC dressing change within 48 hours if gauze under dressing(to better assess site), and every 7 days along with assessments every shift on Treatment Administration Record. DON B reported measures should include external exposed line length and arm circumference. DON B reported staff are expected to report abnormal findings to physician and document in medical record.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review the facility failed to prevent the development and worsening of a pressure ulcer for three (Resident #13, 24, and 45) of seven reviewed, resulting in multiple facility acquired pressure ulcers and the potential for infection and increased pain. Findings Include: Resident #13 Review of the medical record revealed Resident #13 (R13) was admitted to the facility on [DATE] with diagnoses that included hypertension, anxiety, and depression. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R13 was cognitively intact, did not have a pressure ulcer, and was at risk for pressure ulcer development. Review of the same MDS revealed R13 required assistance of one for most activities of daily living. On 05/21/24 at 12:56 PM, R13 was observed in her room. R13 was dressed, nicely groomed, and seated in her wheelchair. Gauze bandages were observed on both of R13's feet and heels. When queried what the purpose of the bandages were, R13 reported that she had cuts (pressure ulcers) on both of her feet. When asked how the cuts on her feet were obtained, R13 replied that the cuts (pressure ulcers) were from her heels resting on her bed for too long. R13 reported that she could not feel her feet due to a chronic peripheral neuropathy (nerve damage that often causes weakness, numbness, and pain, usually in the hands and feet) diagnosis. R13 stated that prior to the development of her pressure ulcers, she did not utilize any devices to assist with keeping her heels off the mattress for pressure reduction purposes. She stated that after staff had discovered the pressure ulcers, they offered her some boots to offload pressure from her heels, but those made her feet very sweaty. R13 stated that after the boots, the facility provided her with a foam wedge to aide in keeping her heels off the bed and she regularly utilized that. Review of an active Physician Order dated 9/8/23 reflected Monitor skin daily with care and full skin checks weekly with shower. Review of the Skin assessment task dated 4/10/24 revealed that R13 was marked for no skin issues. Review of a Shower sheet dated 4/13/24 revealed R13 had received a shower and there were no suspicious skin areas determined. Review of a Progress Note dated 4/15/2024 at 2:12 PM reflected CNA [certified nursing assistant] alerted this writer of skin issue to BIL [bilateral] heels. both heels have what appears to be pressure injuries. R [right] heel is discolored and appears to have been a blister that has popped open. the L [left] heel is discolored but not with a blister. physician and wound nurse notified to assess and set treatment. CNAs and resident were advised to elevate heels whenever in bed. heel foam dressing applied to BIL heels to alleviate possible further breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Skin/Wound dated 4/16/2024 at 1:46 PM revealed Wound nurse notified of skin breakdown to bilateral heels. On assessment, left heel presents with elongated purple discoloration, consistent with deep tissue injury. Right heel presents with large, irregular shaped blister with small pinpoint opening distally, scant serosanguinous [Serosanguineous fluid is a type of wound drainage typically in response to wound damage. The drainage is typically thin and watery with a light red or pink hue] area consistent with a stage two pressure injury. Skin prep applied to intact skin of bilateral heels with foam bordered dressing to cover. Resident initially resistant to offloading heels with pillow or foam boots. With staff encouragement, resident agreeable to use pillow to offload heels or foam boots when in bed . Review of a Skin assessment dated [DATE] revealed R13's left heel was an in house acquired deep tissue injury. The left heel had an area of 0.8 centimeters (cm), length of 2.0 cm, and a width of 0.6 cm. Review of a Skin assessment dated [DATE] revealed R13's right heel was an in house acquired stage two (partial tissue skin loss with exposed dermis). The right heel had an area of 5.8 cm, length of 3.4 cm, and a width of 2.5 cm. A note at the bottom of the skin assessment stated that staff reported that R13 was resistant to change in routine such as offloading heels with pillows in bed. Review of R13's Behavior MDS dated [DATE] revealed that R13 did not have any refusals in care. Review of the Physicians Orders for R13 revealed new orders which included offloading heels at rest which was initiated on 4/15/24, achilliease (wedge) to bed of loading heels which was initiated on 4/19/24, and foam boots to bilateral heels when in bed, as tolerated with an active date of 4/26/24 and a discontinued date of 4/29/24. These orders were implemented after the development of the bilateral heel pressure injuries. Review of a Skin/Wound Note dated 4/23/2024 at 1:12 PM revealed Weekly wound assessment: Deep tissue injury to left heel presents with reduced redness, slight reduction in measurements .Right heel presents with partially ruptured blister (10% open, 90% epithelium), with light serosanguinous drainage . Resident using Achillease to end of bed to float heels, reporting comfort and ease of use . Review of a Skin/Wound Note dated 5/1/2024 at 2:31 PM revealed Weekly wound assessment: Right heel stage two presents with ruptured blister, light serous drainage, no sign of infection. Left heel deep tissue injury presents with stable measurements, epithelium intact. New scab to left heel noted with assessment. Resident reports no pain . Review of a Skin/Wound Note date 5/14/2024 1:56 PM revealed Weekly wound assessment: Left heel pressure injury presents with scabbing along achilles and small open area to heel with light serous exudate. Left heel measurements stable. Right heel pressure injury presents with slough to 90% of wound bed and 10% granulation tissue. Light serous exudate noted . Review of a Skin assessment dated [DATE] revealed R13's left heel fit the description of a Stage Two pressure ulcer. The left heel pressure ulcer had an area of 0.8 cm, a length of 0.9 cm, a width of 1.2 cm, and a depth of 0.1 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Skin assessment dated [DATE] revealed R13's right heel fit the description of a Stage Three pressure ulcer. The right heel pressure ulcer had an area of 3.2 cm, a length of 2.9 cm, a width of 1.4 cm, and a depth of 0.3 cm. In an interview on 05/24/24 11:16 AM, Registered Nurse (RN) F stated that she was the Wound Nurse for the facility and was familiar with R13. RN F reported that prior to the development of the bilateral heel pressure ulcers, the intervention for pressure ulcer prevention in place included a foam mattress. After the discovery of the pressure ulcers on R13's heels, an order was placed to offload her heels with foam boots initially, and then a foam wedge on the end of her bed. RN F stated that just prior to the development of the bilateral heel pressure ulcers, R13 had a health decline which caused her to stay in bed more frequently. RN F stated that she was unaware that R13 had been spending additional time in bed and would have liked to see the intervention of offloading heels in bed implemented during that time. Resident #24 Review of the medical record revealed Resident #24 (R24) was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, muscle weakness, myasthenia gravis, schizoaffective disorder-bipolar type, anxiety disorder, major depressive disorder, displaced bimalleolar fracture of left lower leg, closed fracture with routine healing, dislocation of left ankle joint, and orthostatic hypotension. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R24 was cognitively intact with a Brief Interview for Mental Status of 12, did not have a pressure ulcer, and was at risk for pressure ulcer development. Review of R24's Care Plan revealed R24 required limited assistance by one person for bed mobility and utilized the Hoyer lift for transfers. On 5/21/24 at 11:20 AM, R24 was observed in bed. R24 had an ACE wrap on his lower left extremity along with a hard boot. His left lower extremity was resting directly on the mattress. R24 was pleasantly confused and did not appear to answer questions appropriately. When asked how R24 notified staff if he needs anything, R24 held up his bed remote and stated, well I don't know, I haven't thought about that before. When asked what happened to his left leg, R24 stated oh, I don't know. They say I have a bad habit. Review of the Hospital Discharge Summary dated 2/22/24 revealed R24 admitted to the trauma service after experiencing a fall at home resulting in a left ankle dislocation and fracture. An external fixator device (a device which consists of a metal frame and pins surgically placed into the bone to help maintain the length, alignment, and rotation of the fracture) was placed on 2/15/24. Post-operative assessments revealed that R24's left external fixator device was in place and wrapped with an ACE bandage to protect the skin from the device. R24 was able to wiggle his toes and had no visible injury. Review of the After Visit Summary dated 2/22/24 revealed orthopedic instructions which stated, non weight bearing on left lower extremity . Keep left foot elevated above heart level while at rest: only allow left foot to be in a dependent position for 10-to-15-minute intervals while up/active . Sponge bath only keeping pin sites and surrounding dressings dry . please change out dry dressings on pins daily as needed when saturated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Physician Order dated 2/22/24 revealed R24 was to maintain a non-weight bearing status on his left lower extremity. Additionally, the order stated May reinforce or replace ACE wrap as needed. Use foam cushion to elevate LLE (left lower extremity). Bed bath only. This order was discontinued on 5/17/24. Review of an After Visit Summary from a follow up orthopedic appointment on 3/1/24 revealed the following instructions: no weight bearing left lower extremity .Xeroform, Kerlix, and ace wrap to LLE. Change daily or more if drainage . apply ice to site several times per day . Review of an After Visit Summary dated 5/17/24 revealed R24 had the external fixator device removed from his left lower extremity. The post operative instructions included instructions to apply ice to the left lower extremity several times a day and to elevate the left lower extremity above heart level while at rest. In an observation on 5/21/24 at 12:36 PM, R24 was observed in bed. R24 had an ACE wrap on his lower left extremity along with a hard boot. His left lower extremity was resting directly on the mattress. R24's left foot was in a relaxed position and was observed to be tilted over and resting on the left lateral side of his foot. In a wound care observation on 05/23/24 at 10:23 AM R24 was observed in bed. R24 had an ACE wrap on his lower left extremity along with a hard boot. His left lower extremity was resting directly on the mattress. R24's left foot was in a relaxed position and was observed to be tilted over and resting on the left lateral side of his foot. Review of a Progress Note dated 5/10/2024 at 6:19 PM Some tenderness noted today when performing dressing change on LLE. Discharge noted on both medial and lateral aspects of the ankle. Used an ABD pad when bandaging today, as it looks like the hardware is being pressed into the left side of the foot, causing pain. Redness noted on tissue surrounding insertion site. Cleaned area with NS, xeroform, ABD for extra cushioning, and Curlix. Wrapped with ACE bandage . Review of a Progress Note dated 5/11/2024 3:44 PM When the nurse did the wound dressing change today, nurse found a pressure injury on the left foot which was related with the medical device .Nurse will notify the wound care nurse to evaluate the skin changes on Monday. Nurse cleansed the pressure injury with normal saline, put the pad in between the pressure injury for protection . Review of a Physician order dated 5/11/24 revealed LLE wound care: NS cleanse, Xeroform, ABD pad to lateral side of foot to protect from hardware pressing in, kerlix and ACE wrap. Change daily or more if drainage . This order was discontinued on 5/17/24. Review of the initial pressure ulcer photograph revealed a pressure ulcer on the lateral side of R24's foot that was caused from the screw and nut of the external fixator device digging into the lateral side of R24's left foot. The pressure ulcer was the same size as the screw and nut and appeared to have an indentation on the skin. The wound bed was covered with slough. Review of a Skin/Wound note dated 5/21/2024 at 1:34 PM revealed Weekly wound assessment: left lateral foot pressure injury presents with slough to ~80% of wound bed and and [sic] pink granulation tissue to remaining wound bed. Light serosanguinous drainage. Depth reduced, remaining measurements stable . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of The Skin and Wound evaluation dated 5/21/23 revealed R24's pressure ulcer was classified as a medical device related unstageable wound. The wound had an area of 1.7 cm, a length of 1.8 cm, a width of 1.3 cm, and a depth of 0.2 cm. In an interview on 05/23/24 at 2:31 PM, Certified Nursing Assistant (CNA) T stated familiarity with R24. CNA T denied seeing a foam cushion used to elevate R24's left lower extremity when R24 had his external fixator applied. In an interview on 5/24/24 at 8:55 AM Certified Nursing Assistant (CNA) D stated familiarity with R24. CNA T denied seeing a foam cushion used to elevate R24's left lower extremity when R24 had his external fixator applied. In an interview on 5/24/24 at 09:07 AM Certified Nursing Assistant (CNA) R stated familiarity with R24. CNA T denied seeing a foam cushion used to elevate R24's left lower extremity when R24 had his external fixator applied. Review of the Kardax (portion of medical record where CNA's access care needs) revealed no instruction to elevate R24's left lower extremity. Review of the Care Plan revealed no instruction to elevate R24's left lower extremity. In an interview on 5/24/24 at 11:33 AM, Registered Nurse (RN) F stated that she was the Wound Nurse for the facility and was familiar with R24. RN F stated that she as unaware of how the medical device related pressure injury developed. RN F stated that the pressure injury should have been prevented if all preventative orthopedic instructions were implemented. RN F stated that R24 was not always compliant. Review of the Progress Notes revealed no refusals for propping R24's foot or refusals of protective ace bandage application. In an interview on 5/24/24 at 3:07 PM, Licensed Practical Nurse (LPN) E stated that she was unsure how R24's medical device related pressure injury developed. Resident #45 Review of the medical record revealed Resident #45 (R45) was admitted to the facility on [DATE] with diagnoses that included overactive bladder, cognitive communication deficit, vascular dementia, severe, with anxiety, and dysphagia. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed R45 was cognitively impaired, did not have a pressure ulcer, and was at risk for pressure ulcer development. Review of the Activity of Daily Living Care Plan revealed R45 required assistance of two people for bed mobility and transferred with the use of a Hoyer. On 5/21/24 at 11:11 AM, R45 was observed lying in bed, positioned toward the left side. R45's right leg was extended straight out with pillow under her lower legs with her heel resting directly on mattress. R45's left leg was bent at the knee and her lateral leg and foot was resting directly on a pillow. A foam dressing was noted on R45's left heel. R45 did not respond when spoke to. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician Order's revealed an active order implemented on 12/6/2023 which stated Keep LLE [left lower extremity] elevated on a pillow r/t [related to] edema. Review of a Skin/Wound Note date 4/17/2024 at 9:06 AM revealed CNA [certified nursing assistant] alerted wound nurse of skin breakdown to left heel. On assessment, small, deep tissue injury noted to medial left heel with small area of blanchable redness just superior .Foam mattress in place, pillow beneath heels (flattened), new foam boots for use in bed to be supplied . Review of a Skin and Wound Evaluation dated 4/17/24 reflected R45 had an in house acquired deep tissue injury on her left heel which had an area of 1.4cm, length of 1.7cm, and a width of 1.2cm. Review of the Care Plan revealed a focus area which stated R45 has a deep tissue injury to the left medial heel and stage two pressure injury to the coccyx related to pressure. A foam mattress intervention was implemented on 4/17/24. Offload heels at rest was implemented on 4/17/24 after the development of the deep tissue injury on the left heel. Review of a Progress Note dated 4/27/2024 at 3:19 PM revealed R45 has a 2cm open area on coccyx area . Review of the Skin and Wound assessment dated [DATE] revealed an in house acquired stage two pressure ulcer. The pressure ulcer had an area of 5.9 cm, a length of 3.7 cm, a width of 3.2 cm, and a depth of 0.1 cm. In an interview on 5/24/24 at 9:43 AM, Certified Nursing Assistant (CNA) W stated that she was familiar with R45's care needs. CNA W stated that R45 required frequent turning and repositioning. In an interview on 5/24/24 at 11:27 AM, Registered Nurse (RN) F stated that she was the Wound Nurse for the facility and was familiar with R45. RN F was notified of her left heel pressure ulcer on 4/17/24. About two weeks later, RN F was notified of the wound on the coccyx. RN F stated that R45's situation and staffing played a role in R45's development of her pressure ulcers. R45's regularly assigned CNA was on vacation causing an irregularity in R45's usual staff, which may have played a role. When asked how R45 developed a pressure ulcer to her left heel when an order for elevating her left foot was already implemented, RN F stated that the use of flat pillows may have contributed. RN F reported that she provided staff education regarding offloading, turning, and repositioning.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to implement timely interventions, provide appropriate supervision and ensure that staff assisted with transfers to prevent recurrent falls for two resident (Resident #70 and #547) of three reviewed for falls, resulting in a head laceration requiring emergency care and staples. Finding include: Resident #70(R70) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R70 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease, polyosteoarthritis, wedge compression lumbar fracture, spinal stenosis, radiculopathy, disc degeneration, low back pain, unsteadiness on feet, reduced mobility, repeat falls, assistance with personal care and anxiety. The MDS reflected R70 had a BIM (assessment tool) score of 13 which indicated his ability to make daily decisions was cognitively intact, and he required max assist with transfers. R70 MDS reflected no behaviors including rejection of care. During an observation and interview on 5/21/24 at 9:24 AM, R70 was observed sitting in chair with wife at side. R70 reported currently planning on surgical procedure this week and elevated pain related for need for back surgery. R70 and family reported R70 had history of falls prior to admission that contributed to current pain and had a fall at the facility on 4/15/24, three days after admission on 4/12/24. R70 and family reported R70 was admitted into room toward end of hall, room [ROOM NUMBER], and door was closed and R70 called wife from cell phone to say he had fallen and hit his head on 4/15/24 and did not no how to get help. R70 family reported she had been home ill and attempted to call the facility to assist R70 but no one answered at the facility. R70 family reported called friend to go to facility an check on R70 and continued several attempts to reach facility by phone and spoke to someone who attended to R70 after several calls and R70 remaining on the floor in room. R70 family reported after staff found R70 he was transferred to the hospital related to head laceration that required several staples. R70 family reported did not want R70 to fall again so family hired one on one sitter to supervised R70 to prevent additional falls to ensure there would not be delay in needed surgical procedure because facility did not have enough staff. Review of the Nursing Progress Note, dated 4/15/2024 at 6:53 p.m., reflected, Staff was called to patient's room after receiving a phone call from patient's wife who was called by patient and stated he had fallen. Patient was observed on the floor in front of his recliner on his right side with obvious lacerations to right side of head. Patient stated I was on my way to the dining area to brush my teeth [named physician] was notified and order received to send patient to ER for further evaluation. Patient's daughter [named], called this nurse for more information, questions answered. (continued on next page)

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the History and Physical, dated 4/15/24, reflected, [named R70] is a [AGE] year-old man with Parkinson ' s disease with Osteoarthritis, osteopenia, history of thoracic compression fracture with history of L1 vertebral compression fracture repair by [named surgeon] and history of left femoral neck fracture on 01/15/2024 with status post ORIF by [named physician]. The patient had mechanical fall at home. The patient had x-rays shows pain on the low back and the patient was taken to the hospital. The patient was diagnosed with L4 compression fracture. The patient had kyphoplasty in setting of the Parkinson ' s disease. The patient is following with neurosurgery. The patient is stabilized. After stabilizing his condition on 04/12/2024, the patient desired to be transferred to the subacute rehabilitation at [namded facility] . Review of R70's Nurse Progress Note, dated 4/15/2024 at 10:03 a.m., reflected.Client was admitted to [named] for rehabilitation on 4/12/24. Client had a fall on 3/13. C/o back pain. Went to [named] hospital, studies showed a L4 compression fracture. Kyphoplasty was performed on 3/27/24. Went to inpatient rehabilitation and then discharged to facility .Client is asking for a stronger pain medication with codeine. Has Ibuprofen scheduled for pain management. Has order for Tylenol PRN. BAT to ABLE. Client requires 2 person assist for transfers . Review of the N ADV Clinical Admission Note dated, 4/12/2024 at 6:44 p.m Level of cognitive impairment: Alert (some forgetfulness). Mental Status Note: Known to get confused at times through the night .Safety Note: Occasionally wakes up confused during the night .Gait is unsteady. Balance is poor . Review of the Fall Risk Evaluation, dated 4/12/2024 at 5:07 p.m., reflected R70 had a high risk for falls with score of 20(>10 equals fall risk). Review of the Fall Incident/Accident Report, dated 4/15/24 at 5:30 p.m., reflected R70 had an unwitnessed fall in room with head laceration to right side of head. The reported reflected R70 was oriented to self. The provided information did no mention when the resident was last observe, toileted, or if intervention was in place or if call light was on. The reported was competed by Licensed Practical Nurse(LPN) Q. During an interview on 5/23/24 at 9:05 AM, LPN Q reported was present for R70 fall on 4/15/24. LPN Q reported was alerted to room when wife called facility by phone and there was a delay because call went to general line first. LPN Q reported eventually R70 wife spoke with Unit Manager on the phone and R70 was then found on the floor in his room with a lot of blood related to head laceration and transfer to hospital via Emergency Medical Services(EMS). LPN Q reported pressure was held to head to control bleeding and EMS transfer R70 from floor to gurney. LPN Q reported R70 returned to the facility with 7 staples that were removed 10 days later. LPN Q reported was unable to recall what other staff were present and verified completed Fall Incident Accident Report the next day because had for got to complete prior to end of shift. LPN Q reported no witness statements were part of investigation. LPN Q reported was unsure how long R70 had been on the floor before alerted by wife on phone and was unsure if investigation completed. LPN Q reported design of rehab rooms makes it difficult for residents to be seen from hall and can not physically visualize all rooms from one area. During an interview on 5/23/24 at 12:52 PM, Director of Nursing (DON) B reported no witness statements for falls including R70 and R547 falls with injury who both required hospital transfers for staples within 72 hours of admission. DON B reported recent identified need for improvement with root cause analysis and additional information gathered at the time of the falls. DON B reported IDT note should be part of fall report and progress notes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/24/24 at 9:54 AM, Registered Nurse (RN) F reported was responsible for completing fall investigations at facility. RN F reported R70 had fall on 4/15/24 in room and was unable to answer how long resident was on the floor prior to staff arrival and reported R70 room was moved closer to Nurse Station after returning from the hospital for increased supervision. RN F verified R70 was at high risk for falls on admission. Resident #547 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R547 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included Hypotension(low blood pressure), history of falls including fall with traumatic subdural hematoma and craniotomy in 2023, acute rash, bilateral lower leg edema, weakness, and abnormal gait. The MDS reflected R547 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with transfers. R547's MDS reflected no behaviors. During an observation on 5/21/24 at 10:17 AM, R547 was noted sitting in recliner, unable to view from hall, in room and appeared calm and able to answer questions with minimal confusion. R547 had a large border dressing over left temple area and reported was related to fall. R547's room was located at the beginning of A Hall about 7 room down from the nurse station. Review of the facility Matrix, dated 5/21/24, reflected R547 admitted to the facility on [DATE] and had a fall with injury. Request for all R547 incident/accidents(I/A) with complete investigations was sent via email to the Nursing Home Administrator(NHA) A on 5/22/24 at 3:34 PM. Received two fall with injury I/A reports for R547, dated 5/17/24 and 5/20/24, on 5/22/24 at 4:33 p.m. The provided documents included I/A report with no evidence of witness statements. Review of the facility, Fall Risk Evaluation,, dated 5/15/24, reflected R547 had a score of 14 that indicated high risk for fall. Review of the Intra Disciplinary Team(IDT) Progress Note, dated 5/16/2024 at 9:42, reflected, Client was admitted to facility for rehabilitation on 5/15/24. Went to [named] hospital on 5/10 from [named adult foster care] for generalized weakness and a rash. Also had edema to BLE[bilateral lower extremities] and increased confusion. Primary diagnosis .Metabolic Encephalopathy. Also diagnosed with Malaise, Failure to Thrive, Edema, Rash, Leukocytosis. PMH[past medical history]: Hypotension, Subdural Hemorrhage, Neurocognitive Deficits .2 Person for transfers . Review of the Physician Progress Note, dated 5/16/24, reflected, She was seen today for admission assessment in her room. She was sitting in a chair, comfortably reports no pain, but feels concerned about her risk of falls. She is a [AGE] year-old female, who had a history of subdural hematoma last year and had a craniotomy XXX[AGE] year female with history of subdural, hematoma status post craniotomy, hypertension and falls, is admitted for skilled care after being in the hospital for worsening leg edema, contact, dermatitis, and mental status changes .Her goal is to be able to return home after improving her balance, Gait and strength .PT and OT evaluation and treatment . (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Review of the Incident Progress Note, dated 5/17/24 at 4:27 p.m., reflected, Staff alerted nurses to patient's room via emergency call light system, patient observed on her left side, bleeding from her head, pressure dressing applied to the laceration to the upper left side of her head. VSS, neurochecks WNL, AxO x4 at time of incident, EMS transport service arrived for transport to [named emergency room] for further tx, [named physician] notified, [named], patient's son, returned call and was updated on patient's incident.

Review of the facility I/A Fall with Injury Report, dated 5/17/24 at 4:35 p.m., reflected R547 was alert and oriented and had an unwitnessed fall coming out of bathroom and found in doorway of room bleeding from left temple area. The report did not mention when resident was last observed or if call light was on at the time of the fall. The reported reflected, Upon return from ED and IDT review: intervention to education on importance of call light use. AXOx4, able to demonstrate use of call light and understanding of when to use.

Review of the Baseline Care Plan(BLCP) Summary, dated 5/15/24, reflected R547 fall prevention measure in place that included, oriented to room, encouraged use of call light, and ensure items in place/reach. The BLCP included interventions that included one to two persons assist with toileting, transfers and two person assist with bed mobility. The BLCP indicated R547 used a wheelchair for mobility and included, Fall Risk under other care plan considerations.

Review of the facility Working Schedules, dated 5/17/24, reflected 2 nurses and 3 cna staff for 45 rooms on first floor including one cna call in.

During an interview on 5/24/24 at 9:00 AM, Licensed Practical Nurse (LPN) Q reported was R547 nurse on 5/17/24 at the time of the fall. LPN Q reported R547 had self transferred to bathroom and fell in room coming out of bathroom and hit head and was found in doorway with laceration to left temple with a large pool of blood on floor. LPN Q reported pressure was held to head to control the bleeding and vitals taken and EMS transferred R547 off the floor to the emergency room . LPN Q was unsure when resident last observed prior to fall or if call light was on. LPN Q reported R547 returned to the facility with 7 to 8 stable to left side of head and reported was very concerned post fall related to history of fall with subdural hematoma and craniotomy and decision to send R547 directly to hospital for follow up. LPN Q reported was unable to recall other staff present. LPN Q reported unfortunately the facility layout had a poor design for rehab because not able to physically be in view of all rooms from any one location. LPN Q reported rehab unit with several new admissions and with large turn over rates. LPN Q reported poor decision to place new residents with high acuity and high risk for falls at end of unit with less foot traffic because increases the risk for residents who need more supervision. LPN Q reported example of current resident in furthest end of hall(not visible from main nurse station) was new admission post hospital admission for respiratory failure, extubated the day prior, with confusion and high risk for falls.

Review of the Nursing Progress Note, dated 5/20/2024 2:10 PM, reflected, CNA alerted this writer to resident's room. resident had fallen when ambulating from the BR back to room, hitting head on the floor. CNA was present and witnessed fall but unable to stop fall. resident remained alert and talking to staff. laceration to L temple area. resident assisted up to w/c. laceration cleansed with NS and dry dressing applied. vitals obtained and are wnl, no other injuries observed and pain denied. staff will continue to monitor.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility I/A Fall with Injury Report, dated 5/20/24 at 1:30 PM, reflected, CNA alerted this writer to resident's room. resident had fallen when ambulating from the BR[bathroom] back to room, hitting head on the floor. (Same type of fall as on 5/17/24) resident was walking with walker. CNA was present and witnessed fall but unable to stop fall. resident remained alert and talking to staff. laceration to L temple area. The report reflected, IDT review of fall: intervention to encourage non-slip footwear when up, as patient had removed shoes. Continue with therapy efforts to address gait impairments (has crisscross step patterns). The report did not mention the last time R547 was observed prior to the fall, last toileted, if the call light was on or off or if gait belt had been used during the transfer. Review of the Care Plans, dated 5/17/24 through 5/20/24, reflected no new interventions post 5/17/24 fall that required hospital visit and several staples to left temple area related to laceration. Review of the Progress Notes, dated 5/17/24 to 5/20/24, reflected no mention of follow up fall documentation. During an interview on 5/24/24 at 9:54 AM, Registered Nurse(RN) F reported was responsible for fall investigations along with Director of Nursing(DON) B and also verify appropriate interventions in place. Reported R547 had history of fall upon admission on 5/15/24 and had unwitnessed fall on 5/17/24 post self transfer that caused left head laceration and staples. RN F reported intervention was to remind R547 to use call light. RN F was unable to answer if that same intervention was effective prior to the 5/17/24 fall. RN F reported staff were expected to document fall Progress Note every shift for 3 days post fall and verified R547 did not have any post fall progress notes in the medical record and was unsure why. RN F reported R547 had additional fall with similar situation and hit head that caused another head laceration on 5/20/24(3 days after prior fall with head laceration, hospital transfer and staples). RN F verified R547 did not have any new interventions added to the fall care plan after the 5/17/24 fall with injury and should have. RN F verified nurse staff had indicated post fall charting had been completed in the Treatment Administration Record after the 5/20/24 fall but was unable to locate complete post fall charting every shift for 3 days.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to ensure resident received an assessment for meal consumption assistance and received sufficient food intake, in one of four residents reviewed for nutrition and hydration (Resident #24), resulting in significant weight loss. Findings include: Resident #24 Review of the medical record revealed Resident #24 (R24) was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, muscle weakness, myasthenia gravis, schizoaffective disorder-bipolar type, anxiety disorder, major depressive disorder, displaced bimalleolar fracture of left lower leg; closed fracture with routine healing, dislocation of left ankle joint, and orthostatic hypotension. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R24 was cognitively intact with a Brief Interview for Mental Status of 12, did not have a pressure ulcer, and was at risk for pressure ulcer development. Review of R24's Care Plan revealed R24 was independent for eating. On 5/21/24 at 11:20 AM, R24 was observed in bed. R24 had an ACE wrap on his lower left extremity along with a hard boot. R24 was pleasantly confused and did not appear to answer questions appropriately. When asked how R24 notifies staff if he needs anything, R24 held up his bed remote and stated, well I don't know, I haven't thought about that before. When asked what happened to his left leg, R24 stated oh, I don't know. They say I have a bad habit. On 5/21/24 at 12:56 PM, R24 was observed in bed with his lunch on his bedside table. R24 had not consumed any of his lunch and appeared to be sleeping. R24 woke up when spoken to, however, did not stay alert and awake for more than 30 seconds. On 05/21/24 at 1:30 PM, Med Pass Fortified Nutritional Shake Medication (Med Pass- a supplemental drink used to assist with acquiring additional nutrition) was observed in a cup with a straw unattended on R24's bedside table. On 5/21/24 at 3:06 PM, the Med Pass was observed untouched on R24's bedside table. In an interview on 5/21/24 at 3:12 PM, Licensed Practical Nurse (LPN) E stated that Med Pass should be administered to R24 and not left out on the bedside table. In an interview on 5/22/24 at 3:16 PM, CNA X reported to the nurse that R24 did not eat lunch the day prior on 5/21/24 and did not consume any of his breakfast on 5/22/24. Review of R24's weights revealed the following: On 2/22/2024 R24 weighted 207.8 Lbs. (pounds). On 2/27/2024 R24 weighted 194.0 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/2024 R24 weighted 205.0 Lbs. On 4/3/2024 R24 weighted 183.9 Lbs. On 5/2/2024 R24 weighted 169.0 Lbs. On 5/21/2024 R24 weighted 165.1 Lbs. On 02/22/2024, the resident weighed 207.8 lbs. On 05/21/2024, R24 weighed 165.1 pounds which is a -20. 55 % (percent) loss. On 5/23/24 08:19 AM, R24 was observed in bed. R24's breakfast tray was placed on the bedside table in front of him. Breakfast consisted of an omelet, toast, and a banana. The breakfast tray did not contain any beverages. R24 did not awaken when spoken to. On 5/24/24 at 8:40 AM, R24 was observed in bed. R24's breakfast tray was placed on the bedside table in front of him. R24 reported that he did not have an appetite. A cup of orange juice was observed on R24's bedside table with a date of 5/23. The cup did not contain a straw and was nearly full. A water cup was observed on the bedside table labeled with the date of 5/23. The cup of water was nearly full. Review of R24's Food Acceptable Record revealed R24 had several days where he consumed 50% or less of his meal. In an interview on 5/24/24 at 11:57 AM, CNA (Certified Nursing Assistant) R stated that R24 was not staying awake during breakfast and lunch mealtimes, therefore, was not consuming much of his meals. Review of a Dietary-Nutrition Profile note dated 3/1/24 revealed R24 was being evaluated for admission. R24's current weight was 208 lbs. R24 was ordered a Mighty Shake supplement to be given at lunch time for self-reported poor appetite and to increase nutritional needs required for wound healing. Review of the notes revealed the next nutritional assessment occurred on 5/17/24. The Nutrition High Risk note stated RD {Registered Dietician] met with resident to discuss new wound and refusal of reweight/suspected continued weight loss. Resident had lunch tray at bedside but was sleeping at time of visit. Attempted to speak with resident and offered to feed resident lunch .MightyShake on tray untouched. Notified nurse and CNA's that resident was unable to fully wake up, reported that this is baseline for resident at times . recommend to discontinue MightShake. Add MedPass 2.0 90 ml [milliliters] TID [twice a day] plan to follow up when resident more aware . In an interview on 5/24/24 at 12:05 PM, Registered Dietician (RD) V stated that when a resident is newly admitted to the facility she will visit with the resident and monitor how the resident does consuming their meal. RD V will make a therapy recommendation if she feels that the resident requires assistance with their meals. RD V stated that monitoring intake for R24 has been difficult due to his decrease in cognition and alertness. When R24 first admitted to the facility, he was able to conversate with RD V, however, when she attempted another nutritional assessment with him after she observed his weight loss, R24 was unable to stay awake and seemed different. RD V stated that she implemented administering Med Pass in-between meals to assist in desired weight gain.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 This citation pertains to intakes: MI00142495, MI00142637 Based on observation, interview and record review, the facility failed to ensure sufficient levels of nursing staff to meet resident needs and supervision for two residents (Resident #70 and #547), resulting in repeat falls including injury, and the potential for unmet care needs and facility residents to not attain or maintain the highest practicable physical, mental, and psychosocial well-being. Finding include: Review of the Facility assessment, dated 8/1/23, reflected average census 83. Review of the assessment included data based on census of 93(5/21/23 census of 88), of which 86 required assistance of one or two staff for bathing, 86 required assistance of one or two staff for dressing, 72 required assistance of one or two staff for transferring, 82 required assistance of one or two staff for toilet use, and 82 required assistance of one or two staff for eating. The assessment also revealed 6 residents were dependent on staff for bathing, 3 were dependent on staff for dressing, 14 were depending on staff for transferring, 6 were dependent on staff for toilet use, and 3 were dependent on staff for eating. Resident #70(R70) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R70 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease, polyosteoarthritis, wedge compression lumbar fracture, spinal stenosis, radiculopathy, disc degeneration, low back pain, unsteadiness on feet, reduced mobility, repeat falls, assistance with personal care and anxiety. The MDS reflected R70 had a BIM (assessment tool) score of 13 which indicated his ability to make daily decisions was cognitively intact, and he required max assist with transfers. R70 MDS reflected no behaviors including rejection of care. During an observation and interview on 5/21/24 at 9:24 AM, R70 was observed sitting in chair with wife at side. R70 reported currently planning on surgical procedure this week and elevated pain related for need for back surgery. R70 and family reported R70 had history of falls prior to admission that contributed to current pain and had a fall at the facility on 4/15/24, three days after admission on 4/12/24. R70 and family reported R70 was admitted into room toward end of hall, room [ROOM NUMBER], and door was closed and R70 called wife from cell phone to say he had fallen and hit his head on 4/15/24 and did not no how to get help. R70 family reported she had been home ill and attempted to call the facility to assist R70 but no one answered at the facility. R70 family reported called friend to go to facility an check on R70 and continued several attempts to reach facility by phone and spoke to someone who attended to R70 after several calls and R70 remaining on the floor in room. R70 family reported after staff found R70 he was transferred to the hospital related to head laceration that required several staples. R70 family reported did not want R70 to fall again so family hired one on one sitter to supervised R70 to prevent additional falls to ensure there would not be delay in needed surgical procedure because facility did not have enough staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note, dated 4/15/2024 at 6:53 p.m., reflected, Staff was called to patient's room after receiving a phone call from patient's wife who was called by patient and stated he had fallen. Patient was observed on the floor in front of his recliner on his right side with obvious lacerations to right side of head. Patient stated I was on my way to the dining area to brush my teeth [named physician] was notified and order received to send patient to ER for further evaluation. Patient's daughter [named], called this nurse for more information, questions answered. Review of the History and Physical, dated 4/15/24, reflected, [named R70] is a [AGE] year-old man with Parkinson ' s disease with Osteoarthritis, osteopenia, history of thoracic compression fracture with history of L1 vertebral compression fracture repair by [named surgeon] and history of left femoral neck fracture on 01/15/2024 with status post ORIF by [named physician]. The patient had mechanical fall at home. The patient had x-rays shows pain on the low back and the patient was taken to the hospital. The patient was diagnosed with L4 compression fracture. The patient had kyphoplasty in setting of the Parkinson ' s disease. The patient is following with neurosurgery. The patient is stabilized. After stabilizing his condition on 04/12/2024, the patient desired to be transferred to the subacute rehabilitation at [namded facility] . Review of R70's Nurse Progress Note, dated 4/15/2024 at 10:03 a.m., reflected.Client was admitted to [named] for rehabilitation on 4/12/24. Client had a fall on 3/13. C/o back pain. Went to [named] hospital, studies showed a L4 compression fracture. Kyphoplasty was performed on 3/27/24. Went to inpatient rehabilitation and then discharged to facility .Client is asking for a stronger pain medication with codeine. Has Ibuprofen scheduled for pain management. Has order for Tylenol PRN. BAT to ABLE. Client requires 2 person assist for transfers . Review of the N ADV Clinical Admission Note dated, 4/12/2024 at 6:44 p.m Level of cognitive impairment: Alert (some forgetfulness). Mental Status Note: Known to get confused at times through the night .Safety Note: Occasionally wakes up confused during the night .Gait is unsteady. Balance is poor . Review of the Fall Risk Evaluation, dated 4/12/2024 at 5:07 p.m., reflected R70 had a high risk for falls with score of 20(>10 equals fall risk). Review of the Fall Incident/Accident Report, dated 4/15/24 at 5:30 p.m., reflected R70 had an unwitnessed fall in room with head laceration to right side of head. The reported reflected R70 was oriented to self. The provided information did no mention when the resident was last observe, toileted, or if intervention was in place or if call light was on. The reported was competed by Licensed Practical Nurse(LPN) Q. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 9:05 AM, LPN Q reported was present for R70 fall on 4/15/24. LPN Q reported was alerted to room when wife called facility by phone and there was a delay because call went to general line first. LPN Q reported eventually R70 wife spoke with Unit Manager on the phone and R70 was then found on the floor in his room with a lot of blood related to head laceration and transfer to hospital via Emergency Medical Services(EMS). LPN Q reported pressure was held to head to control bleeding and EMS transfer R70 from floor to gurney. LPN Q reported R70 returned to the facility with 7 staples that were removed 10 days later. LPN Q reported was unable to recall what other staff were present and verified completed Fall Incident Accident Report the next day because had for got to complete prior to end of shift. LPN Q reported no witness statements were part of investigation. LPN Q reported was unsure how long R70 had been on the floor before alerted by wife on phone and was unsure if investigation completed. LPN Q reported design of rehab rooms makes it difficult for residents to be seen from hall and can not physically visualize all rooms from one area. During an interview on 5/23/24 at 12:52 PM, Director of Nursing (DON) B reported no witness statements for falls including R70 and R547 falls with injury who both required hospital transfers for staples within 72 hours of admission. DON B reported recent identified need for improvement with root cause analysis and additional information gathered at the time of the falls. DON B reported IDT note should be part of fall report and progress notes. During an interview on 5/24/24 at 9:54 AM, Registered Nurse (RN) F reported was responsible for completing fall investigations at facility. RN F reported R70 had fall on 4/15/24 in room and was unable to answer how long resident was on the floor prior to staff arrival and reported R70 room was moved closer to Nurse Station after returning from the hospital for increased supervision. RN F verified R70 was at high risk for falls on admission. Resident #547(R547) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R547 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included Hypotension(low blood pressure), history of falls including fall with traumatic subdural hematoma and craniotomy in 2023, acute rash, bilateral lower leg edema, weakness, and abnormal gait. The MDS reflected R547 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with transfers. R547's MDS reflected no behaviors. During an observation on 5/21/24 at 10:17 AM, R547 was noted sitting in recliner, unable to view from hall, in room and appeared calm and able to answer questions with minimal confusion. R547 had a large border dressing over left temple area and reported was related to fall. R547's room was located at the beginning of A Hall about 7 room down from the nurse station. Review of the facility Matrix, dated 5/21/24, reflected R547 admitted to the facility on [DATE] and had a fall with injury. Continued review of the Matrix reflected four new admissions had fall with injury and one long term resident had a fall with major injury on the 100 unit first floor. Request for all R547 incident/accidents(I/A) with complete investigations was sent via email to the Nursing Home Administrator(NHA) A on 5/22/24 at 3:34 PM. Received two fall with injury I/A reports for R547, dated 5/17/24 and 5/20/24, on 5/22/24 at 4:33 p.m. The provided documents included I/A report with no evidence of witness statements. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility, Fall Risk Evaluation,, dated 5/15/24, reflected R547 had a score of 14 that indicated high risk for fall. Review of the Intra Disciplinary Team(IDT) Progress Note, dated 5/16/2024 at 9:42, reflected, Client was admitted to facility for rehabilitation on 5/15/24. Went to [named] hospital on 5/10 from [named adult foster care] for generalized weakness and a rash. Also had edema to BLE[bilateral lower extremities] and increased confusion. Primary diagnosis .Metabolic Encephalopathy. Also diagnosed with Malaise, Failure to Thrive, Edema, Rash, Leukocytosis. PMH[past medical history]: Hypotension, Subdural Hemorrhage, Neurocognitive Deficits .2 Person for transfers . Review of the Physician Progress Note, dated 5/16/24, reflected, She was seen today for admission assessment in her room. She was sitting in a chair, comfortably reports no pain, but feels concerned about her risk of falls. She is a [AGE] year-old female, who had a history of subdural hematoma last year and had a craniotomy XXX[AGE] year female with history of subdural, hematoma status post craniotomy, hypertension and falls, is admitted for skilled care after being in the hospital for worsening leg edema, contact, dermatitis, and mental status changes .Her goal is to be able to return home after improving her balance, Gait and strength .PT and OT evaluation and treatment . Review of the Incident Progress Note, dated 5/17/24 at 4:27 p.m., reflected, Staff alerted nurses to patient's room via emergency call light system, patient observed on her left side, bleeding from her head, pressure dressing applied to the laceration to the upper left side of her head. VSS, neurochecks WNL, AxO x4 at time of incident, EMS transport service arrived for transport to [named emergency room] for further tx, [named physician] notified, [named], patient's son, returned call and was updated on patient's incident. Review of the facility I/A Fall with Injury Report, dated 5/17/24 at 4:35 p.m., reflected R547 was alert and oriented and had an unwitnessed fall coming out of bathroom and found in doorway of room bleeding from left temple area. The report did not mention when resident was last observed or if call light was on at the time of the fall. The reported reflected, Upon return from ED and IDT review: intervention to education on importance of call light use. AXOx4, able to demonstrate use of call light and understanding of when to use. Review of the Baseline Care Plan(BLCP) Summary, dated 5/15/24, reflected R547 fall prevention measure in place that included, oriented to room, encouraged use of call light, and ensure items in place/reach. The BLCP included interventions that included one to two persons assist with toileting, transfers and two person assist with bed mobility. The BLCP indicated R547 used a wheelchair for mobility and included, Fall Risk under other care plan considerations. Review of the facility Working Schedules, dated 5/17/24, reflected 2 nurses and 3 cna staff for 45 rooms on first floor including one cna call in. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 9:00 AM, Licensed Practical Nurse (LPN) Q reported was R547 nurse on 5/17/24 at the time of the fall. LPN Q reported R547 had self transferred to bathroom and fell in room coming out of bathroom and hit head and was found in doorway with laceration to left temple with a large pool of blood on floor. LPN Q reported pressure was held to head to control the bleeding and vitals taken and EMS transferred R547 off the floor to the emergency room . LPN Q was unsure when resident last observed prior to fall or if call light was on. LPN Q reported R547 returned to the facility with 7 to 8 stable to left side of head and reported was very concerned post fall related to history of fall with subdural hematoma and craniotomy and decision to send R547 directly to hospital for follow up. LPN Q reported was unable to recall other staff present. LPN Q reported unfortunately the facility layout had a poor design for rehab because not able to physically be in view of all rooms from any one location. LPN Q reported rehab unit with several new admissions and with large turn over rates. LPN Q reported poor decision to place new residents with high acuity and high risk for falls at end of unit with less foot traffic because increases the risk for residents who need more supervision. LPN Q reported example of current resident in furthest end of hall(not visible from main nurse station) was new admission post hospital admission for respiratory failure, extubated the day prior, with confusion and high risk for falls. Review of the Nursing Progress Note, dated 5/20/2024 2:10 PM, reflected, CNA alerted this writer to resident's room. resident had fallen when ambulating from the BR back to room, hitting head on the floor. CNA was present and witnessed fall but unable to stop fall. resident remained alert and talking to staff. laceration to L temple area. resident assisted up to w/c. laceration cleansed with NS and dry dressing applied. vitals obtained and are wnl, no other injuries observed and pain denied. staff will continue to monitor. Review of the facility I/A Fall with Injury Report, dated 5/20/24 at 1:30 PM, reflected, CNA alerted this writer to resident's room. resident had fallen when ambulating from the BR[bathroom] back to room, hitting head on the floor. (Same type of fall as on 5/17/24) resident was walking with walker. CNA was present and witnessed fall but unable to stop fall. resident remained alert and talking to staff. laceration to L temple area. The report reflected, IDT review of fall: intervention to encourage non-slip footwear when up, as patient had removed shoes. Continue with therapy efforts to address gait impairments (has crisscross step patterns). The report did not mention the last time R547 was observed prior to the fall, last toileted, if the call light was on or off or if gait belt had been used during the transfer. Review of the Care Plans, dated 5/17/24 through 5/20/24, reflected no new interventions post 5/17/24 fall that required hospital visit and several staples to left temple area related to laceration. Review of the Progress Notes, dated 5/17/24 to 5/20/24, reflected no mention of follow up fall documentation. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 9:54 AM, Registered Nurse(RN) F reported was responsible for fall investigations along with Director of Nursing(DON) B and also verify appropriate interventions in place. Reported R547 had history of fall upon admission on 5/15/24 and had unwitnessed fall on 5/17/24 post self transfer that caused left head laceration and staples. RN F reported intervention was to remind R547 to use call light. RN F was unable to answer if that same intervention was effective prior to the 5/17/24 fall. RN F reported staff were expected to document fall Progress Note every shift for 3 days post fall and verified R547 did not have any post fall progress notes in the medical record and was unsure why. RN F reported R547 had additional fall with similar situation and hit head that caused another head laceration on 5/20/24(3 days after prior fall with head laceration, hospital transfer and staples). RN F verified R547 did not have any new interventions added to the fall care plan after the 5/17/24 fall with injury and should have. RN F verified nurse staff had indicated post fall charting had been completed in the Treatment Administration Record after the 5/20/24 fall but was unable to locate complete post fall charting every shift for 3 days. Review of the Facility assessment, dated 8/1/23, reflected average census 83. Review of the assessment included data based on census of 93(5/21/23 census of 88), of which 86 required assistance of one or two staff for bathing, 86 required assistance of one or two staff for dressing, 72 required assistance of one or two staff for transferring, 82 required assistance of one or two staff for toilet use, and 82 required assistance of one or two staff for eating. The assessment also revealed 6 residents were dependent on staff for bathing, 3 were dependent on staff for dressing, 14 were depending on staff for transferring, 6 were dependent on staff for toilet use, and 3 were dependent on staff for eating.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review the facility failed to ensure the attending physician documented in the medical record that identified medication review irregularities were reviewed, the action taken, and/or the rationale for no changes to the medications for one (Resident #30) of five reviewed. Findings include: Resident #30 (R30) Review of the medical record revealed R30 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, schizophrenia, and major depressive disorder. The Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 2/12/24 revealed R30 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 4/13/23 revealed an order for risperidone (antipsychotic medication) 8 milligrams (mg) by mouth at bedtime for schizophrenia. Review of the Recommendations to the Prescriber from the Pharmacist revealed the following: 8/27/23: The pharmacist recommended decreasing the dose of pantoprazole from 40 mg daily to 20 mg daily. The recommendation was not addressed and there was no documentation in the medical record that reflected why the order was not changed. 12/31/23: The pharmacist again recommended decreasing the dose of pantoprazole from 40 mg daily to 20 mg daily. The physician/prescriber response was to maintain the dose related to R30's tracheostomy. This was not documented in the medical record and/or the form was not scanned into the medical record. 3/18/24: The pharmacist recommended obtaining a fasting lipid panel due to the potential of antipsychotic medications to cause hyperlipidemia. The recommendation was not addressed and there was no documentation in the medical record to reflect why the lipid panel was not obtained. 5/16/24: The pharmacist recommended laboratory tests which included a lipid panel. The physician agreed and wrote to write an order to check every six months. Review of R30's medical record revealed the last lipid panel was done on 2/21/23. In an interview on 05/24/24 at 11:16 AM, Director of Nursing (DON) B agreed R30's recommendations from 8/27/23 and 3/18/24 were not addressed. DON B agreed the physician follow up to the recommendation on 12/31/23 was not documented in the medical record. DON B reported the order for laboratory tests recommended on 5/16/24 was written on 5/24/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to ensure adequate monitoring with the use of an antipsychotic medication for one (Resident #30) of five reviewed. Findings include: Review of the medical record revealed R30 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, schizophrenia, and major depressive disorder. The Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 2/12/24 revealed R30 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 4/13/23 revealed an order for risperidone (antipsychotic medication) 8 milligrams (mg) by mouth at bedtime for schizophrenia. Review of the Physician's Order dated 8/27/20 revealed an order to check lipid panel every 6 months. Review of the Recommendations to the Prescriber from the Pharmacist dated 3/18/24 revealed Antipsychotic medications may induce hyperlipidemia. Please consider obtaining a Fasting Lipid Panel at next lab draw. Last lipid in [medical record] was drawn on 2/21/23. Review of the Recommendations to the Prescriber from the Pharmacist dated 5/16/24, revealed the pharmacist again recommended a Fasting Lipid Panel. Review of R30's medical record revealed the last lipid panel was done on 2/21/23. In an interview on 05/24/24 at 12:31 PM, Director of Nursing (DON) B reported R30's most recent lipid panel was completed in February 2023.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5% when two medication errors were observed from a total of 25 opportunities for one resident (Resident #40) of five reviewed for medication administration, resulting in a medication error rate of 8%. Findings include: Review of the medical record revealed Resident #40 (R40) was admitted to the facility on [DATE]. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/24 revealed R40 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 05/23/24 at 8:42 AM, Licensed Practical Nurse (LPN) L was observed preparing and administering medications to Resident #40 (R40). LPN L administered bisacodyl (laxative medication) 5 milligrams (5 mg), did not administer a probiotic, and did not administer loperamide. Review of the Physician's Order dated 4/12/24 revealed an order for a probiotic daily for gastrointestinal health. Review of the Physician's Order dated 8/2/23 revealed an order for Loperamide HCl (used to treat diarrhea) 2 mg by mouth one time a day for loose stools and give 2 mg by mouth every 4 hours as needed for diarrhea. R40 did not have an order for bisacodyl. When asked why R40 was given bisacodyl, LPN L reported they gave bisacodyl because loperamide was not in stock. When asked about the probiotic, LPN L reported the medication was also not in stock, although LPN L had documented the medication as administered to R40. Review of R40's bowel movement documentation, revealed they had loose stool/diarrhea on 5/23/24 at 12:57 PM. In an interview on 05/24/24 at 11:15 AM, Director of Nursing (DON) B reported the facility kept probiotics as a stock medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 88 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and cross-connections between the potable (drinking) and non-potable (non-drinking) water supplies. Findings include: On 05/21/24 at 08:50 A.M., An initial tour of the food service was conducted with Director of Food and Beverage G. The following items were noted: The TurboChef oven interior surface was observed soiled with accumulated and encrusted food residue. Director of Food and Beverage G indicated he would have staff thoroughly clean and sanitize the TurboChef oven interior surface as soon as possible. The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The Vegetable Preparation sink faucet assembly was observed leaking water. The overhead spray arm spring, adjacent to the mechanical dish machine, was observed weak allowing the valve assembly to invade the flood plane level of the sink basin. The 2017 FDA Model Food Code section 5-205.15 states: A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair. On 05/21/24 at 10:05 A.M., An initial tour of the Center for Health & Rehabilitation (CHR) 2 Kitchenette was conducted with Director of Food and Beverage G and Assistant CHR Dining Room Manager H. The following item was noted: The Juice Machine interior surface was observed soiled with accumulated and encrusted food residue. Director of Food and Beverage G indicated he would have staff thoroughly clean and sanitize the Juice Machine interior surface as soon as possible. The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/23/24 at 10:15 A.M., Record review of the Policy/Procedure entitled: Maintenance Service dated 10/19/23 revealed under Objective: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Record review of the Policy/Procedure entitled: Maintenance Service dated 10/19/23 further revealed the following: (1) The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. On 05/23/24 at 10:30 A.M., Record review of the Policy/Procedure entitled: Cleaning Kitchenettes in Health Center dated 06/20/2001 revealed under Policy: Kitchenette cupboards, drawers, refrigerators, and other equipment will be cleaned on a regular basis, by Nursing and Hospitality Services staff. Record review of the Policy/Procedure entitled: Cleaning Kitchenettes in Health Center dated 06/20/2001 further revealed under Procedure: Hospitality Services/Kitchen Staff Responsibilities: Clean/Sanitize: (6) Juice/Cocoa/Coffee Machines.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to offer pneumococcal immunizations per Centers for Disease Control and Prevention (CDC) recommendations for two (Resident #24 and Resident #69) of five reviewed. Findings include: Resident #24 (R24) Review of the medical record revealed R24 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included diabetes and chronic kidney disease stage 3. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/29/24 revealed R24 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the immunization history in R24's medical record revealed they received the Pnemovax 23 on 10/20/15 and refused Prevnar 13. Review of the Immunization Informed Consent revealed on 11/17/22, R24's medical decision maker gave consent for a pneumococcal immunization. According to CDC's PneumoRecs VaxAdvisor, the recommendations for R24 were Give one dose of PCV15 or PCV20 at least 1 year after their last dose of PPSV23. Regardless of which vaccine is used (PCV15 or PCV20), their pneumococcal vaccinations are complete. Resident #69 (R69) Review of the medical record revealed R69 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, hypertension, and obstructive sleep apnea. The MDS with an ARD of 4/18/24 revealed R69 scored 14 out of 15 (cognitively intact) on the BIMS. Review of the immunization history entered in R69's medical record revealed they received Pneumovax 23 on 7/21/11 and 10/28/15. Review of the Immunization Informed Consent revealed on 11/11/22, R69 gave consent for a pneumococcal immunization. According to CDC's PneumoRecs VaxAdvisor, the recommendations for R69 were Give one dose of PCV15 or PCV20 at least 1 year after the last dose of PPSV23. Regardless of which vaccine is used (PCV15 or PCV20), their pneumococcal vaccinations are complete. In an interview on 05/24/24 at 8:34 AM, Infection Preventionist (IP) M agreed R24 and R69 were both due for and consented to a pneumococcal immunization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to offer an updated COVID-19 vaccine to one (Resident #69) of five reviewed. Findings include: Review of the medical record revealed Resident #69 (R69) was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, hypertension, and obstructive sleep apnea. The MDS with an ARD of 4/18/24 revealed R69 scored 14 out of 15 (cognitively intact) on the BIMS. Review of the immunization history entered in R69's medical record revealed their last COVID-19 vaccine was received on 1/16/23. There was no documentation that R69 was offered an updated 2023-2024 COVID-19 vaccine. In an interview on 05/24/24 at 8:34 AM, Infection Preventionist (IP) M reported R69 was due for another COVID-19 vaccine. When asked if a consent or declination was received from R69, IP M reported they did not have record of a consent or declination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024

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

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 88 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Finding include: On 05/21/24 at 02:55 P.M., An environmental tour of the facility Laundry Service was conducted with Director of Building and Grounds I. The following items were noted: Chemical Room: The entrance door laminate surface was observed (etched, scored, particulate), adjacent to the doorknob lock set assembly. The damaged laminate surface measured approximately 6-inches-wide by 8-inches-long. The exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. On 05/22/24 at 09:55 A.M., A common area environmental tour was conducted with Director of Building and Grounds I and Housekeeping Supervisor J. The following items were noted: 1st Floor: B-Hall: Shower Room: 2 of 2 return-air-exhaust ventilation grills were observed with accumulated and encrusted dust and dirt deposits. Housekeeping Supervisor J indicated she would have staff thoroughly clean the ventilation grills as soon as possible. C-Hall: The public restroom commode base seat was observed loose-to-mount. The seat could be moved from side to side approximately 4-6 inches. The restroom ceiling surface was also observed stained from a previous moisture leak. The damaged restroom ceiling surface measured approximately 12-inches-wide by 12-inches-long. Soiled Utility Room: The Laboratory Specimen Refrigerator freezing compartment was observed 1/3 occluded with accumulated ice [NAME]. Director of Building and Grounds I indicated he would have staff defrost the refrigeration unit as soon as possible. Mop Closet: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. 1 of 2 overhead fluorescent light bulbs was also observed non-functional. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Burcham Hills Retirement Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Therapy Restroom: The return-air-exhaust ventilation grill was observed with accumulated and encrusted dust and dirt deposits. 3rd Floor Mop Closet: The mop sink basin was observed (etched, scored, cracked). The plaster wall surface was also observed (etched, scored, particulate), adjacent to the mop sink basin. The damaged plaster surface measured approximately 3-feet-wide by 2-feet-high. O8 Public Restroom: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. On 05/22/24 at 11:50 A.M., An interview was conducted with Director of Building and Grounds I regarding the facility maintenance work order system. Director of Building and Grounds I stated: We have the WorxHub software system. On 05/22/24 at 03:30 P.M., An environmental tour of sampled resident rooms was conducted with Director of Building and Grounds I and Housekeeping Supervisor J. The following items were noted: 103: The return-air-ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. 124: The drywall surface was observed (etched, scored, particulate), adjacent to the restroom hand sink basin. The damaged drywall surface measured approximately 6-inches-wide by 12-inches-long. 303: The restroom vinyl base coving was observed loose-to-mount. The loose vinyl base coving measured approximately 6-feet-long. 306: The restroom vinyl base coving was observed loose-to-mount and missing. The missing vinyl base coving measured approximately 15-feet-long. 307: The restroom vinyl base coving was observed missing. The missing vinyl base coving measured approximately 7-feet-long. On 05/23/24 at 10:00 A.M., Record review of the Policy/Procedure entitled: Maintenance Service dated 10/19/2023 revealed under Objective: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Record review of the Policy/Procedure entitled: Maintenance Service dated 10/19/2023 further revealed under Procedure: (1) The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. On 05/23/24 at 10:15 A.M., Record review of the WorxHub Simple Work Order Listing for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.