STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235262	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hickory Haven	3310 W Commerce Rd Milford, MI 48380

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48680 This Citation pertains to intake MI00143562. Based on interview and record review, the facility failed to provide and document evidence of prompt resolution to grievances identified by family for one (R907) resident of one resident reviewed for activity of daily living(ADLs) resulting in unresolved grievances and the potential for the resident not be assisted with meals. Findings include: Review of a complaint filed with the State Agency (SA) included concerns with the quality of care R907 had received while being in care of the facility. On 4/10/24 at 9:42AM an interview was conducted with Family Member C. Family Member C went on to state that R907 was in the intense critical care unit (ICU) for 3 days, R907 was very ill and the facility caused it. Family Member C stated, I had the facility send [R907] to the hospital for a urinary tract infection(UTI), when they returned to the facility they completed their antibiotics and once the antibiotics was completed I asked the facility if they could conduct another urinalysis culture and sensitivity because I had taken care of R907's super pubic catheter for 6 years prior to being admitted to this facility so I was aware that there were frequent UTIs and [R907] had become resistant to a lot of antibiotic treatments. I spoke with the physician assistant and explained my concern and she stated she would not order anything because [R907] was fine. A few days later [R907] was sent to the emergency room , and was admitted to the ICU because they were becoming septic and had pneumonia and remained in the hospital for 2 weeks. We decided to place [R907] on hospice because of this situation. The facility also has [R907]'s dentures. Family Member C stated R907 also required assistance with meals, and staff would not help with meal times which resulted in R907 not eating and losing weight because food was not opened and set up appropriate for them. On 4/10/24 a copy of all grievances for R907 was requested and the facility did provide. The grievance received on 2/26/24 was submitted by the ombudsman and it wrote visited with resident today 2/26/24 at lunch time, food is not cut up, still does not have adaptive silverware, should have a plate with built up sides, unopened snacks- should have been opened for them. The facility responded to the grievance on 4/10/24 with kitchen to cut up food and supply adaptive silverware, certified nursing assistants to check food is cut up with proper silverware in place. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 11:11 AM the Director of nursing (DON) was interviewed and asked how does the facility address grievances and what is the time frame for follow up. The DON replied, When the grievance is verbal we write it down and address it immediately and put in a progress note. If it is an email we address it just as quick. Then once the concern has been addressed we contact the person that made the grievance and let them know what we did and see if they are satisfied with the changes and then put the response in the progress notes. I would call the family back. The DON was asked what happened in the case with R907 with the grievance that was submitted on 2/26/24 and it was followed up on 4/10/24 with out any follow up progress notes and R907 was discharged from facility on 3/22/24. The DON replied, We followed up immediately. We even started education with staff in regard to assisting with meals. The DON was then asked to provide the educations they did with staff and was asked if she aware of R907's missing dentures (as noted on the progress note dated 3/26/24). The DON replied that she was not aware that dentures were missing and that she would ask the administrator. On 4/10/24 the DON provided the education for helping with meal time in regards to the grievance dated for 4/9/24 as the start date of education. No additional information was provided by the exit of survey.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to intake #MI00143690. Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for two (R905 & R906) of nine residents reviewed for abuse resulting in R906's right arm fracture when R906 was pushed to the floor by R905 as heard by (R909). Findings include: Review of a Facility Reported Incident (FRI) dated 3/21/24 revealed there was a resident to resident physical abuse incident which resulted in injury. On 4/10/24 at 11:35 AM, R906 was observed walking in their room with a sling on their right arm. R906 was asked about the sling. R906 explained it (right arm) was broken and it hurt a lot. When asked how their arm was broken, R906 explained they had been taking a puzzle to R905's spouse when R906 pushed them and R906 fell to the floor and broke their arm. R906 was asked if they ever had any interaction with R906 before that incident. R906 explained R905 had been their roommate, but they had a disagreement and R906 had moved out of the room. R906 was asked if anyone had witnessed the altercation when their arm was broken. R906 explained that R909 had told them they had heard the whole thing. Review of the clinical record revealed R906 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses according to the face sheet that included: 3-part fracture of surgical neck of right humerus (right upper arm), dementia with anxiety and insomnia. According to the Minimum Data Set (MDS) assessment dated [DATE], R906 scored 11/15 on the Brief Interview for Mental Status (BIMS) exam, indicating moderately impaired cognition. Review of the closed record revealed R905 was admitted into the facility on [DATE] with diagnoses that included: encephalopathy, adjustment disorder with anxiety and stroke. According to the MDS assessment dated [DATE], R905 scored 10/15 on the BIMS exam, indicating moderately impaired cognition. Review of R905's progress notes revealed a nursing note dated 3/20/24 at 6:02 PM read in part, Resident had a verbal altercation with roommate resident was moved . Review of R906's progress notes revealed a nursing note dated 3/21/24 at 7:01 PM read in part, .Writer heard resident yell out 'OH!' Writer turned around only to observe resident lying in the hallway on (their) right side saying '(R905) pushed me down!' Other resident was standingover [sic] (them) trying to help (them) off the floor. Both residents were separated .ROM (range of motion) attempted on R (right) arm but resident could not move it and was in pain ratin [sic] 10/10 .911 called .transported resident to hospital for evaluation. Review of R906's hospital discharge paperwork revealed a discharge diagnosis, 2-part displaced fracture of surgical neck of right humerus. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a psychiatric note for R905 dated 3/25/24 read in part, .Pt (patient) had an altercation with (their) ex-roommate on 3/21; and (they) ended up pushing (their) ex-roommate resulting in a fall and right arm fracture . On 4/10/24 at 2:07 PM, R909 that stated they heard the whole thing was interviewed and asked about the incident between R905 and R906 and explained they were lying in their bed with the door closed, but heard R905 and R906 arguing loudly and heard R906 say, 'Let go of me! You're hurting me!' then there was a loud crash. The resident then proceeded to explain that they got out of bed and opened the door and R905 was on the floor, flat on their back. Review of the clinical record revealed R909 was admitted into the facility on [DATE] with diagnoses that included: heart failure, gastro-esophageal reflux disease and osteoarthritis. According to the MDS assessment dated [DATE], R909 had a score of 13/15 on the BIMS exam, indicating intact cognition. On 4/10/24 at 2:33 PM, the Director of Nursing (DON), who served as the Abuse Coordinator, was interviewed and asked about R906's broken arm. The DON explained there was a physical altercation that occurred between R905 and R906 that resulted in R906 falling and breaking their arm. When informed of the interview with R909 hearing the altercation, the DON explained she had interviewed R909 right after the incident and R909's story was the same. Review of a facility policy titled, Identification of Abuse revised 3/2019 read in part, .Abuse is defined .as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm' . Physical abuse includes hitting, slapping, pinching, kicking etc .Physical abuse has occurred whenever there had been some type of impermissible or unjustifiable physical contact that has resulted in injury or harm . Willful: As used in the definition of abuse, 'means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm'.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00143562. Based on interview and record review, the facility failed to maintain a system to account for the accurate usage and reconciliation of controlled medications for two (R908 and R906) of three residents reviewed for medication administration, resulting in the potential for medication errors and drug diversion. Findings include: Review of a complaint received by the State Agency identified concerns that medications were not being administered per the physician's orders. It should be noted that the facility was recently found to be out of compliance with medication administration during the recertification survey on 2/7/24 and had a plan of correction date of 3/5/24. R908 On 4/10/24 at 11:15 AM, the Director of Nursing (DON) was requested to provide all controlled substance records for R908 since March 2024. Review of the clinical record revealed R908 was admitted into the facility on [DATE], readmitted on [DATE] and had not been discharged since readmission. Diagnoses included: unspecified dementia moderate with anxiety, brief psychotic disorder, unilateral primary osteoarthritis, and acute respiratory failure with hypoxia. According to the Minimum Data Set (MDS) assessment dated [DATE], R908 had severe cognitive impairment and received scheduled and as needed (PRN) pain medication. A significant change MDS assessment was in progress due to the resident being signed onto hospice on 4/3/24. Review of the Controlled Drug Receipt/Record/Disposition (CDR) record for R908's Morphine Oral Concentrate (Roxanol - a narcotic pain medication) 20 MG/ML (Milligrams/Milliliters) 0.25 ML (5 MG) by mouth every four hours as needed and the Medication Administration Records (MARs) revealed the following discrepancies: On 4/5/24 at 7:30 PM, 0.25 ML was removed on the CDR, but not signed by the nurse on the MAR. On 4/7/24 at 6:30 AM, 0.25 ML was removed on the CDR, but not signed by the nurse on the MAR. On 4/8/24 at 12:00 AM, 0.25 ML was removed on the CDR, but not signed by the nurse on the MAR. Review of the CDR for R908's Lorazepam (Ativan - an antianxiety medication) 0.5 MG 1 tablet by mouth one time a day at bedtime (HS)/1 tablet by mouth one time a day as needed for anxiety and agitation and the MARs revealed the following discrepancies: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This CDR form was documented as received by the pharmacy on 2/28/24 with a quantity of 30 tablets received. From 3/11/24 to 3/20/24, the MARs documented (via a check mark) that the scheduled Lorazepam 0.5 MG was administered. However, review of the CDR revealed multiple discrepancies which included: The CDR form had no documentation of Lorazepam medication removal from 3/11/24 to 3/20/24. The first entry of medication removal for the above medication was on 3/10/24 at 7:58 AM with a note that one was given and 29 were left. The next entry of medication removal was on 3/21/24 at 8:00 PM which noted one was given and 28 were left. Additionally, further review of the CDR form included the following medication removal for times outside of the physician order (for scheduled at bedtime and one time a day PRN): On 4/7/24 at 1:45 AM, one tablet was given and nine were left. On 4/7/24 at 6:30 AM, one tablet was given and eight were left. On 4/7/24 at HS, one tablet was given and eight were left. R908 received an additional dose of PRN Ativan with no documentation of the discrepancies, or that the physician had been notified. On 4/8/24 at 12:00 AM, one tablet was given and six were left. On 4/8/24 at 4:15 AM, one tablet was given and six were left. R908 received an additional dose of PRN Ativan with no documentation of the discrepancies, or that the physician had been notified. Review of an additional order for Ativan (Lorazepam) from 4/1/24 read, Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth one time only for anxiety until 04/02/2024 07:00 - give at 7:00 a.m. prior to leaving for appnt (appointment). The MAR documented this medication had been given on 4/1/24 at 8:56 PM, instead of 4/2/24 at 7:00 AM, and in addition to the scheduled Lorazepam on 4/1/24 at Review of two CDR forms for R908's Lorazepam 0.5 MG tablet revealed there were two separate entries that a Lorazepam 0.5 MG tablet was removed on 4/1/24 at 9:00 PM; one was removed on the CDR for dated 2/28/24, and one was removed on the CDR form dated 3/18/24. The CDR form dated 3/18/24 contained only two documented removals on 3/22/24 at 9:00 PM with one tablet given and 29 left, and on 4/1/24 at 9:00 PM with one tablet given and 28 left. There was no documentation in the clinical record which addressed these discrepancies such as whether there was an error, physician had been notified, or that the facility had identified a potential medication error. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 12:30 PM, the DON was asked what the process should be for administering controlled medication and reported the nurses should sign off on the paper (CDR form) and write on the form and then document on the MAR, and if they didn't, it was considered a medication error. When asked who was responsible for completing audits and/or monitoring to identify any concerns, the DON reported they were responsible. When asked how often that occurred, the DON reported they usually try to do that once a month. On 4/10/24 at 2:50 PM, the DON was asked to clarify the documentation provided which included both the scheduled and as needed (PRN) medication on the same CDR form and they reported that was their pharmacy's process and had been since they started working in their role about seven months ago. When asked if there were any other additional documentation to provide, the DON reported what was provided was copies of the current CDR forms and originals of the non-current records. The DON reported there was no additional documentation as they had provided what they had available. There was no additional documentation provided by the end of the survey. The DON was unable to explain the discrepancies identified. 39592 R906 On 4/10/24 at 11:35 AM, R906 was observed in their room with a sling on their right arm. R906 was asked about their arm. R906 explained it was broken, and it was very painful, but they had a difficult time getting pain medications when they asked for them. Review of the clinical record revealed R906 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses according to the face sheet that included: 3-part fracture of surgical neck of right humerus (right upper arm), dementia with anxiety and insomnia. According to the Minimum Data Set (MDS) assessment dated [DATE], R906 had moderately impaired cognition. Reconciliation between R906's March 2024 and April 2024 Medication Administration Records (MAR's) and Controlled Drug Receipt/Record/Disposition Forms (CDR) for, Oxycodone 5 mg (milligrams) give 1 tablet by mouth every 8 hours as needed for pain revealed the following discrepancies: 3/9/24 at 9:00 PM one tablet signed out on the CDR, the MAR was blank, indicating the medication was not given. 3/10/24 at 9:00 PM one tablet signed out on the CDR, the MAR was blank. 3/23/24 at 9:00 PM one tablet signed out on the CDR, the MAR was blank. 3/27/24 at 9:00 PM one tablet signed out on the CDR, the MAR was blank. 3/30/24 at 5:00 AM one tablet signed out on the CDR, the MAR was blank. 4/5/24 at 12:07 PM one tablet signed out on the CDR, the MAR documented a tablet was given at 9:38 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/7/24 at 9:00 PM one tablet signed out on the CDR, the MAR was blank. On 4/10/24 at 2:33 PM, the Director of Nursing (DON) was interviewed and asked about the discrepancies between R906's CDR's and MAR's for Oxycodone. The DON explained she was not aware of the discrepancies but would look into the matter. When asked if audits were done on the CDR's, the DON explained she would perform an audit of one CDR from every cart monthly. Review of a facility policy titled, Controlled Medication Storage, Security & Disposition revised 12/2016 read in part, .Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility .