STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake MI00142836. Based on observation, interview, and record review, the facility failed to ensure timely care and services to promote dignity in 3 of 4 residents (Resident #200, #201, & #202) reviewed for dignity/respect, resulting in long call light wait times, cluttered rooms, and the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Resident #200 Review of a Face Sheet revealed Resident #200 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: cellulitis (bacterial infection of the skin), weakness and pressure ulcers. Review of a Minimum Data Set (MDS) assessment for Resident #200, with a reference date of 1/9/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #200 was cognitively intact. In an interview on 4/11/24 at 2:13 PM, Resident #200 reported that call lights take a long time to get answered. Resident #200 reported that during the day is usually the worst, but that recently he had waited 2 hours to have staff reposition him. Resident #200 reported that sometimes his light will get answered fast, but it takes them 45 minutes to find a second person to help. Resident #200 reported frustration with trying to move and maneuver himself into a different position while waiting for assistance. In an interview on 4/12/24 at 12:15 PM, Resident #200 reported that he had waited an hour for his call light to be answered last night on second shift; he had wanted a dry brief, to get cleaned up, and get ready for bed. In an interview on 4/12/24 at 1:49 PM, Director of Nursing (DON) reported that she was not aware of any staffing issues on second or third shift yesterday, and that there was no obvious reason that a call light would have taken 1 hour to be answered. DON reported that the facility did not have a policy or specific timeframe set related to the expectation of staff to respond to call lights. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/12/24 at 2:25 PM, Unit Manager (UM) A reported that on 4/11/24 all shifts were full staffed. Resident #201 During an observation and interview on 4/11/24 at 1:41 PM in Resident #201's room, the call light was on, and Family Member (FM) P was sitting in a chair. FM P reported that the resident needed kleenex to spit into, but that there was none, so he spit onto his gown, and now needs some help with getting cleaned up. FM P reported that many times when she arrived to visit, Resident #201 would be lying in bed with food all over him, and sitting in a wet soiled brief. FM P reported that she often pressed the call light, and it would take up to an hour to get answered. FM P reported that she organized Resident #201's room every time she visited, because there was always trash and clutter all over. Observation of 6 packages of incontinence briefs piled on the residents dresser, along with disposable wipes, bathing products, clean linens, and other miscellaneous belongings stacked up. Resident #202 In an interview on 4/10/24 at 1:55 PM, FM I reported that Resident #202 lived in the facility for a short time before going to the hospital, and that he was in extreme pain from terminal cancer. FM I reported that when she visited he would put his call light on for pain medication or help with toileting, but it would not get answered. FM I reported that she would have to go out onto the unit and find staff to help and that they always acted bothered. Observations made on 4/10/24, 4/11/24 and 4/12/24 of a dry erase board by the nurses station where residents gathered revealed, an outdated posting that read, today is 3/9/24 have a good day it's a full moon and there was a leprechaun drawn on it. There was also permanent print that read, Your staff today: Nurse: CENA's: with placed for names/numbers, but it was left blank.

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F 0600 Level of Harm - Minimal harm or potential for 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** 41027 This citation pertains to intake #MI00143198. Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by staff for 1 of 3 residents (Resident #201) reviewed for abuse, resulting in the potential for a decline in physical, mental, and psychosocial well-being. Findings include: Review of a Face Sheet revealed Resident #201 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke (with paralysis of left side of body), weakness, depression, anxiety, and dementia without behavioral disturbance. Review of a Minimum Data Set (MDS) assessment for Resident #201, with a reference date of 2/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #201 was moderately cognitively impaired. Review of a Facility Reported Incident (FRI) dated 2/20/24 revealed, .Hospice Worker reported (Resident #201) was allegedly punched by a Certified Nurse Aide (CNA) on his upper right bicep. DON examined the bruise and range of motion of his right arm. His bruise was dissipating and he had full range of motion with his right arm . Review of a 5 Day Investigation Summary dated 2/23/24 revealed, .After discussing the incident with DON (Director of Nursing) and SW (Social Worker), Admin(istrator) and DON proceeded to (Resident #201's) room to discuss the alleged physical abuse by staff CNA. (Resident #201) verbalized the event and the reasoning why he thought he was punched. (Resident #201) had soiled his brief. (Resident #201) stated that he called the CNA, a Ni**** and told her not to touch him. After interviewing (Resident #201), the DON examined/assessed his right bicep for range of motion and dissipation of bruised cite. The bruise was still evident but pigmentation was lighter .Interview with (CNA E) revealed: (CNA E) was rounding and found (Resident #201) with the defecation and was trying to clean (Resident #201). When he started calling her names and using racial slurs and began swinging and hitting. (CNA E) left his room and asked, (LPN C), to assist with the care of (Resident #201) because of his behaviors . In an interview on 4/10/24 at 2:18 PM, LPN C reported that on 2/6/24 CNA E had came up to the nurses station and with a loud voice said you all need to get your residents to not call people ni**** . LPN C reported that she then offered her assistance to CNA E, and that they finished Resident #201's incontinence care without any issues. LPN C reported that it was not until days later that Resident #201 started saying that the bruise on his arm was from being punched by a CNA, but that he had deserved it because he had called her a ni****. LPN C reported that after the allegation, she did observe an area of ecchymosis (bruise) on Resident #201's right upper arm. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/11/24 at 9:43 AM, Hospice Registered Nurse (HRN) L reported that she had visited Resident #201 2-3 times per week for the past couple months and that he had never gotten angry with her or refused care. HRN L reported that on 2/20/24 she had observed a bruise on Resident #201's right upper arm and when asked, Resident #201 reported that he had been punched by a staff member. HRN L reported that she had asked about the bruise at a later date and that Resident #201 reported that same allegation. In an interview on 4/11/24 at 10:08 AM, DON reported that on 2/20/24 HRN L informed her that Resident #201 had reported that a CNA had punched him. DON reported that she interviewed Resident #201 and did a head to toe assessment; a purple half dollar sized bruise was observed on Resident #201's right upper arm. DON reported that the facility did not measure or take a photo of the bruise. DON reported that that bruise had since completely resolved. In an interview on 4/11/24 at 10:38 PM, SW G reported that she had interviewed Resident #201 following the allegation and that he told her that a CNA had punched him, and then admitted that he had called her names. SW G reported that Resident #201 had been living there a long time and that she had never known him to make an allegation that staff were abusive to him, and when asked why he waited so long to report it, he said that it was because he had deserved it because he called her a bad name. SW G reported that the CNA accused of the abuse (CNA E) was different and had a very loud, heavy voice. In an interview on 4/11/24 at 11:12 PM, CNA E reported that she was trying to change Resident #201's brief and he was hitting her and calling her racial slurs, so she left the room and got help from LPN C, who then assisted her and they finished incontinence care together. In an interview on 4/11/24 at 1:41 PM, Family Member (FM) P reported that a couple months ago Resident #201 had told them that someone had been mean and rough with him; they did not inform anyone in the facility of the allegation. In an interview on 4/11/24 at 2:51 PM, CNA J reported that 1-2 months ago Resident #201 had complained of pain in his right upper arm during cares, and kept saying that it was because a CNA had hit him. CNA J reported that she told LPN C and was informed that the facility was already aware and was doing an investigation. CNA J reported that Resident #201 was always pleasant and quiet during cares, and never combative. In an interview on 4/12/24 at 12:14 PM, CNA N reported that Resident #201 had never been combative during cares. In an interview on 4/12/24 at 12:21 PM CNA O reported that Resident #201 had never been combative during cares. In an interview and observation on 4/12/24 at 12:57 PM Resident #201 was lying in bed awake and alert. There was a brownish discolored area observed on his right upper arm. Resident #201 reported to this surveyor that the discolored area was from when the woman hit him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with subsequent observation on 4/12/24 at 1:09 PM with DON, after observing the discolored area on Resident #201's right lateral upper arm, reported that it was the general area of the original bruise, but she could not say for positive if it was the residual bruise or a brownish pigmentation that the resident had always had. DON reported that there was no indication in the records that Resident #201 had a round brownish area of pigmentation in his skin history. Review of Resident #201's Hospice Visit Note dated 2/20/24 revealed, .Patient has a bruise on right upper arm . Review of Resident #201's Skin assessment dated [DATE] revealed, .skin impairment .right upper arm, lower than shoulder . Review of Resident #201's Care Plan for behavior related needs revealed, .Resident displays behavioral symptoms. He will make negative racial statements and become combative with staff during care. Resident is currently on Hospice Care. Start Date 02/20/2024. Note that the care plan was developed after the incident occurred. Review of a facility policy Abuse Prevention Program last review date of 1/2024 revealed, .All staff are expected to be in control of their own behavior, are to behave professionall, and should appropriately understand how to work with the nursing home population .(Nursing Home) facilities care for diverse populations including, amound others, residents with dementia, mental disorders, intellectual disabilities, ethnic/cultural differences .The facility assumes the responsibility of ensuring the safety and well-being of each resident they admit. Staff will be held accountable to their actions .(Nursing Home) will not consider striking a combative resident an appropriate response in any situation .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00142836. Based on interview and record review, the facility failed to provide care and services in accordance with professional standards of practice to 1.) ensure physician orders were in place for scheduled pain medications and 2.) accurately document the administration of controlled medications in 1 or 3 residents (Resident #202), reviewed for quality of care, resulting in the potential for ineffective management of pain, and the potential for drug diversion of controlled substances. Findings include: Review of a Face Sheet revealed Resident #202 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: cancer. In an interview on 4/11/24 at 4:01 PM, Registered Nurse (RN) H reported that Resident #202 was not in the facility for very long and was always in a lot of pain. In an interview on 4/10/24 at 1:55 PM, Family Member (FM) I reported that Resident #202 lived in the facility for a short time before going to the hospital, and that he was in extreme pain from terminal cancer. FM I reported that when she visited he would put his call light on for pain medication, but it would not get answered. FM I reported that it was discussed with Resident #202's doctor that his narcotic pain medication be changed to scheduled, instead of PRN (as needed), so that he would not have to call and wait for it. FM I reported that the physician agreed to change the medication, but that it did not get put in place until days later. FM I reported that Resident #202 passed away on 2/18/24 in the hospital. Review of Resident #202's Physician's Note dated 2/12/24 (entered into progress notes on 2/17/24) revealed, .is known to have non-small cell lung cancer with evidence of metastatic (cancer spread) disease to liver and bone .(FM I) made it clear that she wanted her father on scheduled analgesics (pain medication) as getting PRN analgesics was not reliable and simply took too long to obtain .Assessment and Plans: .cont (continue) Oxycodone (narcotic pain medication) 5 mg immediate release every 6 hours as needed . There was no plan noted for scheduled pain medications. Review of Resident #202's Medication Administration Record (MAR) revealed an order for Oxycodone 5 mg every 6 hours PRN with a start date of 2/8/24 that was only administered one time on 2/15/24 at 1:02 PM and was noted as being effective. Review of Resident #202's MAR revealed an order for Oxycodone 5mg every 6 hours (scheduled) with a start date of 2/15/24 at 3:42 PM. This was the medication change that was discussed with the physician on 2/12/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/12/24 at 1:44 PM, Director of Nursing (DON) reported that when a physician visits a resident, new orders should go into effect immediately. DON reported that the physician that saw Resident #202 is no longer employed a the facility, and that there were past known issues related to confusing and missing orders with this physician. DON reported that Resident #202 was terminally ill with cancer, and according to the MAR, Resident #202 did not receive PRN pain medication except for one time on 2/15/24. DON reported that she would see if they still had the controlled substance sign out sheets, to verify that it was not given. In an interview on 4/12/24 at 2:04 PM, Unit Manager (UM) A reported that she was not sure why Resident #202's medication order to change Oxycodone to a scheduled dose was discussed on 2/12/24, but then not changed until 2/15/24. In an interview on 4/12/24 at 2:05 PM, Assistant Director of Nursing (ADON) B reported that she changed Resident #202's order from Oxycodone PRN to a scheduled dose on 2/15/24, but could not recall why that was done, and did not have any documentation to support it. ADON reported that it appeared that Resident #202 was not in pain and/or receiving PRN doses of Oxycodone 5mg. In an interview and review of records on 4/12/24 at 2:45 PM, DON reported that according to the controlled substance sign out sheet for Oxycodone 5 mg PRN, Resident #202 received 9 doses from 2/11/24 at 1:30 PM to 2/16/24 at 6:00 AM. DON reported that these doses were not recorded in the resident MAR. DON reported that in order for the information to be available for everyone, nursing staff were required to document the administration of the medication in the residents MAR. Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, High-quality documentation and reporting are necessary to enhance efficient, individualized patient care. Quality documentation and reporting have five important characteristics: they are factual, accurate, complete, current, and organized . Criteria for thorough communication exist for certain health problems or nursing activities. Your written entries in a patient's medical record describe the nursing care you administer and the patient's response . Timely entries are essential in a patient's ongoing care. Delays in documentation lead to unsafe patient care . [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 350-353

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to maintain safe infection control practices in regard to hand hygiene (glove use), and implement enhanced barrier precautions (EBP) in 1 resident (Resident #200) reviewed for infection control, resulting in the potential for cross-contamination and the development and spread of multi-drug resistant bacteria. Findings include: Review of a Face Sheet revealed Resident #200 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: cellulitis, weakness and pressure ulcers. Review of a Minimum Data Set (MDS) assessment for Resident #200, with a reference date of 1/9/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #200 was cognitively intact. During an observation and interview on 4/10/24 at 11:04 AM Resident #200 was lying in his bed and there was signage outside of his door indicating Enhanced Barrier Precautions .Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing . During an observation on 4/10/24 at 4:00 PM CNA M was in Resident #200's room preparing to transfer him to bed. CNA M was holding the end clap of Resident #200's catheter bag and struggling with it, trying to get it to close properly, CNA M was wearing gloves, but not wearing a gown or goggles. Resident #200 was holding his catheter bag, with the hoyer sling and hooks all set to transfer him from the chair to bed. CNA M reported that the catheter clamp is broke and she needed to go get a nurse. CNA M then removed her gloves and left the room, without performing any hand hygiene. At 4:06 PM CNA M and LPN K walked back into the resident's room, donned only gloves and both staff were now handling the catheter bag clamp. LPN K then reported that she would need to go get a new bag. At 4:09 PM LPN K entered the residents room again holding a new catheter bag, and donned only gloves. LPN K was struggling to remove the old tubing and catheter bag; wearing her gloves she reached into her pocket for scissors, then removed her landyard and began cutting the tape that sealed the cbag tubing onto the catheter tubing. CNA M was holding a basin underneath the area to catch any urine that may drain out. After the new catheter bag was attached, using their same gloves, LPN K and CNA M handled the resident and the hoyer, and transferred the resident into his bed. Resident #200 had multiple superficial open wounds on his thighs that were not covered adequately by dressings. The resident then began to have a BM (bowel movement), so staff assisted him onto the bedpan. LPN K and CNA M were both still only wearing gloves. There was no PPE (personal protective equipment) cart in sight. In an interview on 4/12/24 at 11:59 AM, CNA O reported that she did not know why Resident #200 was on EBP and stated, maybe for his wounds. CNA O reported that gowns are usually hanging behind the door in the room, but that there was not any hanging at this time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/12/24 at 1:49 PM, DON reported that Resident #200 has EBP ordered due to chronic macerated wounds and a foley catheter. DON reported that anytime direct care is provided, staff should be wearing a gown, gloves and if they are managing his catheter bag, goggles should also be worn.