STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235287	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adrian Bay Rehab and Nursing Center	700 Lakeshire Tr Adrian, MI 49221

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services per standards of practice, facility policy, and per physician's orders for one resident (Resident #575) of one resident reviewed for respiratory services. This deficient practice resulted in respiratory distresss, increased anxiety, missed doses of physician orders nebulizer treatments, and the potential to result in hypoxia [below-normal level of blood oxygen], and respiratory/medical decline with the potential to effect a total of five residents who had nebulizer treatments in the facility. Findings include: Review of the facility, Nebulizer (SVN) Policy, dated 7/11/18, reflected, It is the policy of this facility that Small Volume Nebulizer (SVN) treatments will be administered by licensed nurse and/or respiratory therapist, as ordered by a physician .Supplies: Oxygen delivery system or compressed air and connector tube-Nebulizer-Prescribed medication . Resident #575 (R575) Review of the Face Sheet dated 7/16/24, reflected R575 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease(COPD), hypertension (high blood pressure), lung cancer with mets, and leagally blind. Review of R575 Nursing Progress Note, dated 7/15/24 at 5:45 p.m., reflected, Resident arrived via family car, with niece and son in accompany. Resident alertand oriented X4. Full code until DNR signed by Physician. Resident is legally blind. One assist with walker. Verbalizes needs well. During an observation and interview on 7/16/24 at 11:07 AM, R575 was observed sitting upright in chair leaning forward, appeared short of breath, with oxygen via nasal canula attached to oxygen concentrator set at 3 liters. R575 able to answer questions without any congitive concerns with short responses related to short of breath. R575 room temperature felt warm and humid. R575 reported had admitted to the facility 7/15/24 (yesterday) around dinner time and was upset because facility had not yet provided her with required routine breathing treatments. R575 reported did not sleep well last night related to diffitulting in breathing. R575 reported being told by staff that the facility did not have nebulizer tubing available needed to administer medications. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record(MAR), dated 7/15/24 through 7/16/24, reflected R575 had an order for, Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation))1 vial inhale orally two times a day for COPD. The MAR reflected R575 missed two doses. Continued review of the MAR reflected R575 had an order for, pratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 unspecified inhale orally four times a day for COPD. The MAR reflected R575 had missed three ordered doses. During an interview and observation on 7/16/24 at 11:30 AM, Regisered Nurse(RN) N reported nebulizer tubing was located in the storage room, located between Hall A and Hall B, and opened the door. RN N was observed looking through the entire room and reported was unable to locate any nebulizer tubing and reported central supply staff orders supplies. During an interview and observation on 7/16/24 at 11:38 AM, Central Supply staff (CS) P reported was the facility central supply and reported was responsible for ordering oxygen tubing supplies. CS P reported resident tubing were changed every Monday so supply orders were placed on Tuesdays. CS P verified the facility did not have any nebulizer tubing supplies in the facility currently and reported would place an order for today after looking through supply room. CS P reported was not made aware the facility was out of nebulizer tubing supplies. During an interview on 7/16/24 at 11:48 AM, R575 contuinued to be in room sitting upright and leaning forward with family in the room and appeared short of breath and able to answer questions with short answers related to breathing. R575 family was discussing with Unit Manager of possibly providing R575 with oral inhaler until oxygen company arrived with nebulizer tubing supplies. R575 family reported nebulizer treatments were more effective. During an interview on 7/16/24 at 11:52 AM, RN O reported was informed by night nurse that R575 did not get ordered nebulizer treatments because the facility did not have nebulizer tubing equipment available in the building. RN O reported worked the day shift from 7am to 7pm did not call the physician today to notify of three missed nebulizer treatments today because the night nurse had reported had they notified the physician last night. RN O reported not yet assessed R575 respiratory status including lung sounds, respirations, or oxygen saturation since start of shift at around 7:00 a.m. RN O reported R575's last documented oxygen saturation was on 7/15/24 at 8:00 p.m. at 99%. RN O verified the facility did not have any nebulizer tubing equipment available currently. During an interview on 7/16/24 at 12:01 PM, R575 continued to be in room with additional family at bedside. R575 family reported R575 arrived at the facility yesterday between 4:00 p.m. and 4:30 p.m. and routinely used two types of nebulizer treatments four times daily for COPD and had not yet received any since admission. At 12:06 p.m. R575 another family member had arrived with portable oxygen tank to take R575 home after R575 signed herself out against medical advice(AMA) because she was not receiving ordered breathing treatments. R575 family reported facility did not provide R575 with protable oxygen to move out of room and was at the facility for rehab. R575 continued to have difficulty answering questions related to difficulty in breathing and stated to family, I can't wait to get home to get a treatment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 7/16/24 at 12:15 PM, Maintenance Director(MD) Q reported had worked at the facility for three years and monitors the facility temperatures monthly. MD Q entered R575 room and reported the current temperture by R575 bed, located by the hall door, was 77-78 degrees. MD Q reported the tempurature by the window bed was 75 degrees, located by the air conditioner unit, and the temperaure in the hall was 72 degrees. During an observation on 7/16/24 at 12:17 p.m., observed R575 being assisted out of facility in wheelchair with portable oxygen on. During an observation on 7/16/24 at 12:25 p.m., outside tempurture was around 85 degrees and very humid. During an interview on 7/16/24 12:30 PM, Director of Nursing (DON) B reported R575 was only resident in facility who did not have nebulizer tubing. DON B reported staff exchange all oxygen equipment every mondays and oxygen company supplies facility on wednesdays. DON B verified had checked four other residents that required nebulizer treatments had all been changed and available yesterday. DON B reported this incident propted change in facility policy to have at least 40 nebulizer tubing equipment sets on hand at all times moving forward. DON B reported was not informed the facility was out of nebulizer tubing equipment because staff could have obtained supplies from another local facility and verified was present when R575 was admited. During an interview on 7/16/24 at 3:35 PM, DON B reported nebulizer tubing equipment had been delivered and was available for use in facility currently. During an interview on 7/17/24 at 4:05 pm, DON B reported would expect facility to have enough nebulizer tubing equipment on hand. DON B reported would expect staff to follow Physician orders and contact Physician if orders not followed. DON B reported would expect staff to complete respiratory assessment including if Physician ordered treatments were not available to administer and document in Electronic Medical Record.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility failed to serve the appropriate food consistency for one (Resident 44) of three reviewed for therapeutic diets, resulting in the potential for aspiration and/or choking and continued weight loss. Findings include: Resident #44 (R44) Review of the Admission Record reflected that Resident 44 (R44) was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficultly swallowing) and cerebral infarction (stroke). The quarterly Minimum Data Set (MDS) assessment, dated for 6/24/24, reflected that R44 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS) (a cognitive screening tool). The MDS also reflected that R44 received a soft, bite sized texture for meals. During an observation and interview on 07/16/24 01:58 PM, R44 was resting in bed and had a family member visiting. R44 explained that she had been experiencing some weight loss. R44 stated that she had a difficult time chewing her food and that she wished that her food, particularly the chunks of eggs and meat, were diced up into a finer consistency so that she was able to consume her meals. R44 stated that she received cottage cheese and yogurt for every meal, however, she loves hamburgers and would order a hamburger nearly every day. R44 stated that her food items come cut up into bite sized pieces, but she didn't feel that the cut up food was small enough for her to safely consume. During an interview on 07/16/24 01:58 PM, Family Member (FM) L stated that since R44's stroke, she has had a difficult time chewing and swallowing her food. FM 44 stated that a family member or friend was present during meal times to ensure that R44 does not choke. FM L stated that choking is a constant worry for several family members. FM L confirmed that they were present for several meals and that R44's food was a cut up, bite sized consistency. Review of R44's Electronic Medical Record revealed an active Physician's Order dated for 6/18/24 that reflected R44 was to receive an enhanced diet, soft and bite sized texture, honey like consistency for liquids. R44's nutrition care plan, with an initiation date of 5/6/24, reflected that R44 had a nutritional problem related to a stroke, weight loss, decreased appetite and the need for an altered texture diet. The interventions included, but were not limited to, RD (Registered Dietician) to evaluate and makes diet change recommendations PRN (as needed) Review of a Speech Language Pathologist Communication worksheet dated 7/2/24 revealed R44's diet had been downgraded form Soft and bite sized to a puree diet due to coughing and choking during meals. In an interview on 7/17/24 at 1:57 PM, Certified Nursing Assistant (CNA) E reported that R44 received a soft and bite sized texture diet. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/17/24 at 3:09 PM, FM M was visiting R44. FM M reported familiarity with R44 and stated that she came in and supervised during meal times for R44. FM M stated that when she comes in, she has to assist with cutting up R44's food to even smaller portions to ensure R44 can safely consume the food. R44 often ordered egg salad, however, the chunks of hard boiled egg were to large for R44 to consume so FM M would assist with cutting up the foods. FMM confirmed that R44 was not an a puree diet. In an interview on 7/17/24 at 3:37 PM, Registered Dietician (RD) C stated that R44's current diet order was soft and bite sized foods. When asked to review the Speech evaluation dated 7/2/24, RD C stated that the speech evaluation stated that R44 was downgraded to the puree diet, however, that evaluation was missed. RD C confirmed that R44 should have a puree diet order on 7/2/24. In an interview on 7/17/24 at 4:04 PM, Dietary Manager (DM) D verified that R44 currently had a soft and bite sized texture diet order in place. After review of the 7/2/2024 speech evaluation document, DM D verified that R44 should be on a puree diet.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39083 Based on observation, interview, and record review, the facility failed to install and maintain backflow protection devices and air gaps, resulting in the potential contamination of the facility potable water system, affecting all residents in the facility. Findings include: On 7/17/24 at approximately 9:50 AM, during an inspection of the kitchen, the drain lines of the three-compartment sink, were observed to not be provided with an air gap to prevent backflow of gas, liquid, and solid contaminants into the sink basins if a backflow event were to occur. Additionally, the vegetable and fruit preparation sink was observed to not be provided with an air gap in the drain line. At this time, Dietary Manager D confirmed the finding. On 7/17/24 at approximately 9:55 AM, the steamer at the cookline was observed to not be provided with a backflow protection device to protect the potable water supply. According to the 2017 FDA Food Code Section 5-203.14 Backflow Prevention Device, When Required. A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT, including on a hose [NAME] if a hose is attached or on a hose [NAME] if a hose is not attached and backflow prevention is required by LAW, by: (A) Providing an air gap as specified under S 5-202.13 P; or (B) Installing an APPROVED backflow prevention device as specified under S 5-202.14. On 7/17/24 at 9:59 AM, the dietary mop sink was observed to have a wall mounted chemical dispenser connected to the water fixture. At this time, the water was on, using the chemical dispenser as a shut off valve, leaving the Atmospheric Vacuum Breaker (AVB) (a device commonly used in plumbing to prevent backflow of contaminated water into the potable water supply) under pressure. Leaving the AVB under pressure for a continuous amount of time can damage the integrity of the device, reducing the effectiveness of backflow protection. According to the 2017 FDA Food Code Section 5-202.14 Backflow Prevention Device, Design Standard. A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device. P On 7/17/24 at 2:56 PM, during an inspection of the facility, the housekeeping office mop sink was observed to have a wall mounted chemical dispenser connected to the water fixture. The AVB was observed to be under pressure with the chemical dispenser used as a shutoff valve.