STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235295	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Extended Care and Rehab	210 South First Street Harbor Beach, MI 48441

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to ensure that physicians' orders for code status was present in the EMR (electronic medical record) for three residents (R15, R19 and R21) of four residents reviewed for advance directives, resulting in the absence of code status orders in the EMR and the potential for the resident's preference for life sustaining treatment to not be followed by the facility. Findings include: Resident #19: R19 is [AGE] years old and readmitted to the facility most recently on 03/19/2019 with diagnoses that include paraplegia, chronic pain, muscle wasting and contractures of the bilateral upper extremities. R19 has a BIMS (brief interview for mental status) score of 15 indicating they are cognitively intact. On 11/18/24 at 02:24 PM, record review revealed there was no physician order for code status in the EMR (electronic medical record). A signed DNR (do not resuscitate) form was in the paper chart at the nurse's station. On 11/20/24 at 11:13 AM, record review revealed a physician's order for DNR was entered in the EMR, the order was created and signed by the physician on 11/18/24 at 20:58 (8:50 PM). This was after it was brought to the attention of the staff by this surveyor. Resident #21: R21 is [AGE] years old and most recently readmitted to the facility on [DATE] with diagnoses that include hypertension, gout, urinary retention and chronic kidney disease. R21 has a BIMS score of 13 indicating they are cognitively intact. On 11/18/24 at 04:06 PM, record review revealed there was no physician's order for code status located in the EMR. A signed full code form was in the paper chart at the nurse's station. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 11:20 AM, record review revealed that a physician's order for full code status was entered in the EMR, the order was created and signed by the physician on 11/18/24 at 20:55 (8:55 PM). This was after it was brought to the attention of the staff by this surveyor. On 11/20/24 at 11:22 AM, an interview was conducted with the DON (director of nursing) The DON was asked how the staff members identify a resident's code status in an emergent situation. The DON replied that the outside binder on the paper charts has a sticker that says DNR and that is how staff would know what the code status is. The DON stated that if there is not a DNR sticker on the outside of the binder then the resident is a full code. The DON was asked if residents should have an order in the chart to identify their code status. The DON stated yes, they should have an active code status order in the EMR from the physician. Record review of the policy titled, Residents' Rights Regarding Treatment and Advance Directives, approved 6/04/2024, revealed: Policy: It is the policy of Lakeview Extended Care and Rehab to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. Procedure: I. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. IX. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. 37771 Resident #15: A review of Resident #15's medical record revealed an admission into the facility on [DATE] with a readmission on 10/5/21 with diagnoses that included non-traumatic brain dysfunction, abnormalities of gait and mobility, and dementia. A review of the Minimum Data Set assessment dated [DATE], revealed the resident was cognitively intact and needed substantial/maximal assistance with most activities of daily living and needed supervision or touching assistance to partial/moderate assistance with most transfers and mobility. On 11/18/24 at 4:00 PM, a record review of Resident #15's medical records revealed the Resident had a Do Not Resuscitate (DNR) status for code status. Review of the medical record with the Director of Nursing revealed no physician order for the DNR code status. On 11/19/24 at 9:59 AM, a record review of Resident #15's medical records revealed the Resident had Do Not Resuscitate status and an order was obtained by the facility with an order entry for the DNR code status dated for 11/18/24 at 8:50 PM. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 11:40 AM, an interview was conducted with the Director of Nursing (DON) regarding physician order for Resident #15's code status. The DON reported that for whatever reason, when they have a change in the medical record number, it did not carry over and stated, They should have an active order for code status.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37771 Based on observation, interview, and record review, the facility failed to ensure a sanitary and homelike environment in the residents' bathroom and communal shower room, for four residents (#9, #13, #15, #16), and residents that use the shower room), of five residents reviewed for homelike environment, resulting in the potential for embarrassment, dissatisfaction of living conditions, and spread of infection.]Findings include: Resident #9: An observation was made on 11/18/24 at 9:55 AM in Resident #9's bathroom of a denture cup under the hot water faucet handle at the sink. The lid of the denture cup was positioned just under the faucet handle. On 11/18/24 at 1:24 PM, an observation was made in Resident #9's room of the denture cup that was positioned under the hot water faucet handle of the sink. The room was shared with two residents. Resident #13: An observation was made on 11/18/24 at 9:56 AM of a denture cup positioned under the hot water faucet handle of the sink. Can not wash hands without the potential to drip or come in contact with the top of the denture cup. The room was shared with two residents. An observation was made in the bathroom of a bedpan inside a bag and stored on top of toilet paper behind the toilet. On 11/18/24 a 12:37 PM, an observation was made in Resident #13's room of the denture cup stored under the hot water faucet handle of the sink. Resident #15: An observation was made on 11/18/24 at 9:52 AM of the Resident dressed and sitting up in their wheelchair. An observation was made in the Resident's bathroom of a denture cup under the hot water faucet handle where drips or hands can come in contact with the denture up when hands were washed. On 11/18/24 at 1:24 PM, an observation was made in Resident #15's room of a denture cup stored underneath the faucet handle of the sink. The room is shared by two residents. Resident #16: An observation was made on 11/18/14 at 9:50 AM in Resident #16's room of a denture cup stored under the cold-water faucet handle of the sink. In the bathroom a bed pan in a bag was stored in a bin under the sink with multiple bottles of shampoo and other bottles of personal items. Shower Room: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 1:48 PM, an observation was made of the shower room on the one end of the unit. The shower room had a shower chair positioned in the area of the shower stall. Positioned on the floor around the chair were buckets used in a commode chair or on the shower chair that had an opening on the seat for a bucket to be placed. One of the buckets was soiled with a brown substance that looked like bowel movement. Another bucket was turned over and on the floor. Under the sink in the shower room, two buckets were stacked together with the bucket on top with a lid on it. The two stacked buckets were positioned in a basin. There were no resident names on the buckets. On 11/18/24 at 2:00 PM, an observation was conducted with the Director of Nursing (DON) of the one shower room. The buckets stored under the sink were separated and appeared to have been used and not thoroughly cleaned. The buckets stored in the shower area had liquid in the bottom and was not thoroughly cleaned inside and on the outside. The bucket positioned upside down was wet inside and had not been thoroughly cleaned after being used with debris on the inside of the bucket. The DON indicated that was not the way to store the commode buckets and indicated they will be disposed and/or cleaned and stored off the floor. Observations were made, with the DON, of Resident rooms that had a denture cup stored under the faucet handles of the sinks. The DON indicated they should not be stored that way. An observation, of Resident #16's bathroom with the bed pan stored with personal bathing items, was made with the DON. The DON indicated the bedpan was to be stored in the wire rack and the shampoo bottles and lotions were not to be stored with the bedpan. The DON indicated the items might have been brought in by the Resident's family and due to volume of items, they were stored down in that wire rack and reported the lower rack was for the bedpan storage only and the other items can be stored at the Resident's bedside. On 11/18/24 at 2:32 PM, an interview was conducted with the Infection Control Preventionist (ICP), Nurse A regarding the storage of the commode buckets in the bathroom. The ICP Nurse reported conversations with staff about storage of items and stated, last week, talked to staff about the same issue. The ICP Nurse indicated they should be cleaned, dried and put away, not stacked wet or on the floor and stacked together. A review of the denture cups stored under the faucet handles in multiple Resident rooms was reviewed. The ICP Nurse reported the denture cups should not be stored under the faucet handles but should be in the Resident's rack in the bathroom or by the nightstands. A review of facility policy titled, Resident Environmental Quality, revealed, Policy: It is the policy of (facility name) to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public . A review of facility policy titled, Safe and Homelike Environment, revealed, .Definitions: . Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for two residents (Resident #6 and Resident #25), of 12 residents reviewed for care planning, resulting in the potential for unmet care needs and a decline in overall health and wellbeing. Findings include: Resident #6: A review of Resident #6's medical record revealed an admission into the facility on [DATE] with diagnoses that included right femur fracture, diabetes, poly arthritis, chronic pain and dementia. The Resident had an order, dated 5/31/24, Left hand resting hand splint at night-monitor skin integrity. On 11/18/24 at 11:10 AM, an observation was made of Resident #6 sitting in their room. A hand splint was observed among the Resident belongings. The Resident was observed to have right hand finger contracture. The Resident was interviewed, answered questions and engaged in limited conversation. When asked if the Resident could open her fingers up on her right hand, the Resident indicated the fingers would not open on their own. When asked about the hand splint, the Resident indicated they would wear it when I want to. On 11/20/24 at 12:07 PM, an interview was conducted with the Assistant Director of Nursing (ADON) regarding Resident #6's hand splint. The ADON indicated the Resident did not like to wear it and refused it a lot of times, and will hid the appliance in their drawer under clothing. The ADON was asked about care planning for the hand splint. On 11/20/24 at 1:17 PM, the ADON returned and was queried regarding Resident #6's care planning of the hand splint. A review of the care plan with the ADON revealed a care plan for skin integrity to address the potential for skin breakdown with the application of the hand splint. The care plan lacked a focus for the use of the hand splint, interventions or plan of care with the refusals. The Resident had a care plan for restorative therapy and the ADON indicated they should have it under both care plans. Resident #25: A review of Resident #25's medical record revealed an admission into the facility on [DATE] with diagnoses that included pneumonia left lower lobe, anxiety disorder and stroke. On 11/18/24 at 1:42 PM, an observation was made of Resident #25 in their room. The Resident was interviewed and answered questions. The Resident had an incentive spirometer (IS) and a smaller respiratory device. When asked about the items, the Resident reported he uses the incentive spirometer to suck the air up, and the other device the Resident reported it helps him breathe. The Resident reported he did not use the incentive spirometer very often. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 10:43 AM, an observation was made with the Assistant Director of Nursing (ADON) of Resident #25 in his room. The Resident was asked about the incentive spirometer and the Resident stated, I'm supposed to do it, don't do it much. The ADON indicated the other device was a flutter valve. The Resident used the flutter valve by blowing air out and the device made a fluttering sound. A review of Resident #25's care plan with the ADON revealed no care plan for the incentive spirometer or the flutter valve. The ADON indicated that there was not an order for the flutter valve or IS but indicated that they should be care planning for the items. On 11/20/24 at 11:36 AM, an interview was conducted with the Director of Nursing (DON) regarding Resident #25's lack of care planning for the IS and flutter valve. The DON reported Resident #25 had a history of pneumonia and reported for best practice, we want healthy lungs, and indicated a care plan would be implemented and will be included on the care guide as well. A review of facility policy titled, Comprehensive Resident Care Plans, revealed, C. The Interdisciplinary Team (IDT) in coordination with the resident/resident's responsible person will develop and maintain a comprehensive care plan that identifies the highest practicable level of physical, mental, and psychosocial well-being the resident may be expected to attain and/or maintain .

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to notify the physician of an unintended significant weight loss for one resident (Resident #17) of three residents reviewed for nutrition, resulting in a lack of physician oversight and potential interventions for weight loss. Findings include: Resident #17 (R17): R17 is [AGE] years old and readmitted to the facility on [DATE] with diagnoses that include atrial fibrillation, nausea/vomiting, generalized weakness and GERD (gastroesophageal reflux disease). R17 has a BIMS (brief interview for mental status) score of 10 indicating moderate cognitive impairment. On 11/18/24 at 10:19 AM, R17 was asked if they felt like they had lost some weight since being in the facility. R17 stated they think they have lost some weight in the facility and believes it is because of their poor appetite. R17 stated, I really like the food but just don't always have the appetite to eat it. On 11/20/24 at 09:10 AM, record review revealed R17 has experienced an unintended significant weight loss of 10% in the last 6 months. On 04/01/24 R17 weighed 152.5 lbs and on 10/07/24 R17 weighed 135.4 lbs. Record review revealed R17 has a care plan in place for alteration in nutrition status, it last reviewed on 11/04/24. On 11/20/24 at 09:15 AM, a review of a dietary noted dated 10/22/24, indicated that R17 had experienced a significant weight loss in the last six months. The dietary note does not indicate that the physician was notified of the weight loss. On 11/20/24 at 09:27 AM, interview was conducted with CDM (Certified Dietary Manager) C. CDM C indicated that R17 had been acutely ill during the early months of the weight loss. CDM C stated that R17 is currently on a supplement and the current weight loss is being attributed to an acute condition from months ago. CDM C stated R17 is getting 4 oz juice with beneprotein in it for additional protein. CDM C stated R17 receives snacks at 10 am, PM and at bedtime. CDM C stated R17 is receiving monthly weights and their appetite is improving. R17 averages about 40% intake for meals but sometimes will eat 75% or more, R17 was experiencing nausea and at one point was taking Zofran for that. CDM C stated they visit R17 weekly and review the food menu with them. CDM C stated that R17 is always satisfied with her meals, and she likes the food at the facility. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 11:04 AM, an interview was conducted with ADON (Assistant Director of Nursing) B and the DON (Director of Nursing) ADON B was asked what the procedure was for getting resident weights in the facility. ADONB stated the aides weigh the resident and that gets recorded in the chart and given to the dietary managers. ADON B stated the dietary managers review the weights and discuss any weight loss during the care conferences quarterly. ADON B was asked if the physician should be made aware of a weight loss. ADON B stated yes, the physician should be made aware so they can make orders as needed. The DON stated she was unable to locate any documentation that showed the physician was notified of the weight loss. The DON stated nurses can notify the physician via tiger text, but the record of tiger text goes away after a while. The DON stated the nurses should make a progress note that they notified the physician of any weight loss. Review of the policy titled, Weight Monitoring Program, last reviewed 03/20/24 revealed: IX. Suggested Interdisciplinary Nutrition Interventions for Unintended Weight Loss. A. Dietary Considerations -Certified Dietary Manager (CDM) or Registered Dietitian to notify nursing via recommendation form. Nursing will then notify physician of significant weight changes via tiger text or another approved form of communication.