

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Lahser Hills Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 25300 Lahser Rd Southfield, MI 48034	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275</p> <p>This citation pertains to Intake(s): MI00151185</p> <p>Based on observation, interview and record review, the facility failed to ensure an oxygen dependent resident was provided continuous physician ordered respiratory care for one (R601) of two residents reviewed for respiratory care, resulting in R601's SPO2 (blood oxygen saturation level) to have dropped to an abnormal range level and the resident being transferred to the hospital for a higher level of care. Findings include:</p> <p>A Complaint was filed with the State Agency (SA) that alleged that on 3/12/25, R601 was observed in the dining room unattended. R601 was found to be lethargic and slumped over the table with a puddle of urine underneath them. R601's oxygen tank was determined to be empty. In addition, the humidity bottle for the concentrator in their room was also empty. The Complainant noted that R601 was sent to the hospital as their O2 levels were not stable.</p> <p>On 3/26/25 at approximately 10:00 AM, R601 was observed sleeping in bed. The resident was alert but not able to answer any questions asked. The residents O2 concentrator was running at 3L (liters) via a nasal canula.</p> <p>A review of R601's clinical record revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: chronic kidney disease, Chronic Obstructive Pulmonary Disease (COPD), altered mental state, type II diabetes and alcohol abuse. A review of R601's Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8/15 (moderately intact cognition). The resident was noted as their own responsible party and had been receiving Hospice services starting on or about 7/8/24. The resident was also noted as FULL CODE.</p> <p>Continued review of the R601's clinical record revealed, in part, the following:</p> <p>Order (start 6/20/24): Humidified Oxygen 3L/min via Nasal Canula every shift related to Chronic Obstructive Pulmonary Disease .</p> <p>Care Plan: Focus: Potential/Actual alteration in oxygen exchange due to COPD .Intervention: Humidified O2 as ordered: 3 L via Nasal Cannula (3/29/2024) .Focus: ADL (activities of daily living) deficit r/t (related to) COPD with oxygen .Interventions: Transfer 2 PA (person assist) Hoyer to Geri Chair .</p> <p>(continued on next page)</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3/12/25 (4:00 PM) Nurses Note: Received resident at shift change in dining room with empty oxygen tank and soiled brief. Mouth was very dry and and <sic> bloody. Authored by Nurse B</p> <p>O2 Sats (saturation): 3/12/24 (6:04 PM): 80%</p> <p>3/12/25: Change in Condition Evaluation (11:23 PM Lock Date): Resident (R601) .Situation: Abnormal vital signs .Altered Mental Status .Pain .Shortness of Breath .Most Recent Blood Pressure: 60/48 .Most Recent O2 Sats .80% (3/12/2024) .Oxygen via Nasal Canula .Decreased level of consciousness' .Increased confusion .unable to eat or swallow .Describe respiratory changes .Shortness of breath .Abrupt onset of SOB (shortness of breath) .Lack of Oxygen for several hours .send to hospital .</p> <p>3/12/25 (7:11 PM): Resident is full code and on Hospice .Hospice Nurse to evaluate resident. Agreed with decision to transfer out to hospital.</p> <p>Printable Discharge Hospital Form (Last Activity Date 3/19/25): .Chief Complaint: AMS (Altered Mental Status) .History of Present Illness: .diabetes, COPD on home oxygen .Patient is a poor historian .EMS (emergency medical services) was called for low blood pressure and hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) .Upon arrival BP (blood pressure) 88/61 .in ED (emergency department) patient was placed on non-rebreather (a medical device used to deliver a high concentration of oxygen in emergency situation) .</p> <p>On 3/26/25 at approximately 9:55 AM, the facility was asked to provide all IA (Incident/Accident) reports for R601. Reports were received at 11:58 AM. There were no IA's that addressed the incident involving an empty oxygen tank, causing respiratory concerns.</p> <p>On 3/26/25 at approximately 10:40 AM, the Director of Nursing (DON) was interviewed regarding the incident(s) involving R601. The DON was queried as to R601's not continuously receiving ordered O2 and sustaining a SPO2 drop to 80%, the DON reported that they were aware and noted that they had a document that detailed the incident. The DON stated they would forward the document.</p> <p>On 3/25/25 at approximately 12:45 PM, an untitled document provided by the DON was reviewed and documented, in part: .Staff were interviewed .Nurse B was providing care to other residents up until 4:00 PM when she noted resident in respiratory distress. She stated that her (R601) oxygen tank was empty, mouth had dried blood, and her brief needed to be changed. Resident was taken back to her room where she was placed on her concentrator at 3L .The resident was scoring high pain .At this time, the resident's pulse oximetry was 86%. Nurse B increased her oxygen flow to 5L/min and her oxygen level improved (*It should be noted that there is no documentation in the resident's clinical record of the O2 level increasing) .Hospice was contacted .Nurse B reported that when the hospice nurse arrived, she wanted to give PRN (as needed) morphine. When Nurse B checked her vital signs the resident's blood pressure was 60/48 .At this time, it was determined that the resident would be sent out to the hospital .Change in Condition Review .On 3/12/25 at approximately 4 PM, Nurse B, noticed that the resident had labored breathing and hypotension, which resulted in her being sent to the emergency room at approximately 7:44 PM .upon investigation, the resident was taken to the dining room around or shortly after breakfast. She remained in the dining room until approximately 4 PM .Facility has determined that the resources required to stabilize the resident were not available and she required higher level of care .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/25/25 at approximately 3:18 PM, an interview was conducted with Nurse B. Nurse B reported that they have been employed by the facility for about two years and worked as a Registered Nurse (RN) for over [AGE] years. Nurse B was asked about the incident involving R601's respiratory decline. Nurse B reported that they entered the building around 3:00 PM on 3/12/25. Upon entry they spoke with the outgoing nurse and then started to complete rounds. They were assigned to the hall where R601 resided. During their rounds they were approached by a nursing student who reported to them that R601's oxygen tank was empty. Nurse B reported that they went to the dining room and observed R601 slumped over in a wheelchair with an empty oxygen tank on the back of the chair and observed that their mouth was dry and bloody. Nurse B reported that R601 normally sits in a Geri Chair and was surprised to see them in a wheelchair with the empty oxygen tank. Nurse B also reported that the resident generally uses a O2 concentrator to alleviate dry mouth concerns and ensure continuous oxygen. Nurse B reported that concentrators are portable and should have accompanied the resident to the dining room. Nurse B further reported that when they noticed the resident was lethargic, had urinated themselves and appeared to be in pain, they took them back to their room to assess them. Nurse B noted that they hooked them up to their concentrator at the ordered 3 L and had trouble obtaining a pulse ox. R601's oxygen was noted at 80%. They increased it to 5 L and noted that they were able to get their O2 status up to 86%. Nurse B reported that R601's blood pressure was also very low (60/48) showing signs of hypoxia. Nurse B contacted the Hospice nurse who came to the facility and determined that the resident should be sent out to the Hospital.</p> <p>On 3/26/25 at approximately 3:48 PM, a phone interview was conducted with Physician C. Physician C was asked if they were aware of the incident that occurred on 3/12/25. Physician C recalled that R601 was sent to the hospital for hypoxia and low blood pressure.</p> <p>When asked if R601 should continuously be receiving O2, they noted that they should.</p> <p>The facility policy titled, Oxygen Administration was reviewed and documented: .The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify there is a physician's order for the procedure .Steps in the Procedure .Turn on the Oxygen. Unless otherwise ordered start the flow of oxygen . place appropriate oxygen device on the resident . Adjust the oxygen device on the resident so that it is comfortable for the resident and the proper flow of oxygen is being administered .check the .tank .to be sure they are in good working order .</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275</p> <p>This citation pertains to Intake #MI00151195</p> <p>Based on observation, interview and record review the facility failed to timely evaluate the competency of a resident and obtain legal guardianship for a resident with impaired cognition for one (R601) of three residents reviewed for Hospice Services. Findings include:</p> <p>A Complaint was filed with the State Agency (SA) that alleged R601 does not have a guardian, power of attorney, or conservator and they are receiving Hospice Services.</p> <p>On [DATE] at approximately 10:00 AM, R601 was observed sleeping in bed. The resident was alert but not able to answer any questions asked.</p> <p>A review of R601's clinical record revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: chronic kidney disease, Chronic Obstructive Pulmonary Disease (COPD), altered mental state, type II diabetes and alcohol abuse. A review of R601's Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] (moderately intact cognition). The resident was noted as their own responsible party and had been receiving Hospice services starting on or about [DATE]. The resident was also noted as FULL CODE.</p> <p>Continued review of R601's clinical record noted, in part:</p> <p>[DATE]: Social Service Note: Writer met with resident .alert and oriented x2 with forgetfulness and confusion . Discussed end-of-life wishes, full code, she verbalized save my life. No current advanced directives discussed guardianship process with her husband (herein after Husband D) who was present-in-person. Provided copy of guardianship petition .BIMS score ,d+[DATE] (severely cognitively impaired) .</p> <p>[DATE]: Social Service Note: Residents Husband D, came to SW (social worker) office and informed writer that he has to turn my wife over to you guys, I just can't take care of her ,d+[DATE] no more, I have too much going on. Husband D also stated that he needs assistance with .petition for guardianship. He handed writer petition for guardianship not completed and signed his name at the bottom .Writer can smell alcohol on Husband Ds breath .Writer informed Husband D that she will have the business office follow-up with him and that the facility can initiate the petition for guardianship.</p> <p>[DATE]: Active Discharge Planning Note: Discharge care conference was conducted today. Husband D was not present. Resident was signed on to hospice services . *It should be noted that there was no documentation in R601's clinical electronic record that noted the resident and/or Husband D signed the resident onto hospice. There were no documents that noted who was R601's DPOA (Durable Power of Attorney).</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE]: Psychiatric Service Notes: R601 .seen today for scheduled follow-up. Patient was last seen on [DATE] (prior to hospice services) .patient seen in her room .Patient is alert, oriented to herself .believing we are in a hospital but is confused about the date, believing it is [DATE] .</p> <p>[DATE]: Social Service Note: .Resident is currently her own RP (responsible party) no current advanced directive in place .</p> <p>[DATE]: Care Review/Care Conference (lock date [DATE]): .Guardianship discussed with husband due to resident's cognitive impairment/decline. Husband understands importance of guardianship and will let writer know when he is ready to file guardianship .</p> <p>[DATE]: Psychiatric Service Notes: .Patient was seen in her room resident in her bed and appeared very lethargic .patient was unable to answer questions .</p> <p>[DATE]: Initial Social Service Assessment: R601 Cognitive Abilities: Resident unable to engage in BIMS assessment, severely impaired cognition .unable to make needs know at this time .Plan to inquire about guardian .</p> <p>[DATE]: Hospital Records: History of Present Illness' .Patient is poor historian .Phone call placed to patients emergency contact/spouse (Husband D) with no answer .Patient was receiving hospice services .discharged from their service today .Palliative Care Progress Note: .Notes also indicating that there has been difficulty reaching patients spouse and may be concerns for domestic violence, patient may need legal guardian to make timely medical decisions on behalf of patient .patient at bedside, .nonverbal, unable to follow commands, unable to participate in goals of care discussion at this time .</p> <p>On [DATE] at approximately 12:32 PM, an interview and record review were conducted with Social Worker (SW)E and Social Service Employee (SSE) F. SW E reported that they were a licensed MSW and SSE F noted that they were not a licensed social worker. Both SSD E and SSE F were queried as to the facility policy(s) /protocol regarding guardianship, competency evaluations and end-of-life wishes including Hospice. SSE F was specifically queried as to their notes dated [DATE] and [DATE] that indicated they recommended starting legal guardianship why nothing had been completed for over 11 months. SSE F reported that they had attempted to have Husband D complete the paperwork, but it has still not been done. SSE F was asked if they had made any attempts to seek alternative Guardianship as they were not able to obtain paperwork from Husband D. SSE E stated they had not. When asked if attempts were made to seek a competency evaluation for R601, they noted that they had not. Both SSE E and SW F were asked to locate documentation pertaining to who agreed and signed off to place R601 on hospice services on or about [DATE] and again on [DATE] when R601 returned from a week's stay at the hospital. Both SW E and SSE F were not able to locate documentation at that time and were not sure on who completed the hospice forms. SSE F was asked if they had discussed Hospice services with R601, including their wishes for code status, hospitalization .</p> <p>On [DATE] at approximately 2:00 PM, a Hospice agreement signed by Husband D was provided. The document(s) dated [DATE] noted the following: .Admission Consent . Lists Patient Name: R601 .My designee is (has R601's name scratched out with Husband D's name in place) .Document titled Opioid Start Talking) .Patient name: [R601] .Name of controlled substance .Morphine Concentrate .Dosage 100 mg/5 .20 mg .) Signed by Husband D Physicians Orders for Scope of Treatment .DO NOT attempt Resuscitation/CPR (NO CPR, allow Natural Death) .Comfort-Focused treatment .</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at approximately 2:28 PM, a phone interview was conducted with Husband D. Husband D was asked about Guardianship and the Hospice consent form that was signed on [DATE]. Husband D reported that nobody at the facility was giving him assistance or contacting him about hospice. He reported that he did not have transportation and felt he was bamboozled into signing the hospice form when someone came to the house and wasn't even clear on what he was signing. He further noted that he had not seen R601 in over a month and wanted them to return home.</p> <p>On [DATE] at approximately 4:00 PM, the facility provided the original consent for Hospice (dated [DATE] signed by R601). The documents provided did not include consent for morphine or any document for Scope of Treatment.</p> <p>The facility policy titled, Job Description/Social Worker was reviewed and in part, read: .The social worker provides Social Services to residents, their families, and significant others to enable them to deal with the impact of illness and extended care plan .Assisting residents/responsible parties with financial and legal matters such as drafting petitions for guardianship/conservatorship .Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions .</p>