STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Fountain Nursing & Rehabilitation Center	18591 Quarry Rd Riverview, MI 48192

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intakes: MI00144232, MI00144376, MI00144543, and MI00144585. Based on observation, interview, and record review, the facility failed to ensure call lights were answered promptly for four residents (R810, R811, R812, and R805) reviewed for accommodation of needs resulting in various unmet health care needs. Findings include: Review of multiple complaints reported to the State Agency (SA) included allegations that call lights were not answered timely (beyond half an hour and longer). Observations on 6/5/24 at 2:00 PM revealed that three call lights were on for the A/B hall (R810, R811, and R812). It is unknown when the call lights were originally activated by the residents. Resident 810 On 6/5/24 at 2:10 PM R810's call light remained on. R810 was observed seated on the edge of the bed with the call light in hand. R810 said she needed assistance to go to the bathroom and the call light had been on for over 15 minutes. R810 said, It takes a long time for them to answer the call light. Usually over a half hour and sometimes over an hour on the night shift. At 2:20 PM, R810 was assisted to the bathroom by Nurse Unit Manager Registered Nurse (RN) B. According to R810's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included chronic obstructive pulmonary disease and falls. R810 was identified to have intact cognition. Resident 811 On 6/5/24 at 2:13 PM R811's call light remained on. R811 was seated in a wheelchair next to her bed. R811 said she had been up in her chair since breakfast and wanted to go back to bed, but her bed had not been made up. R811's bed did not have a linen on it. R811 said she asked to go back to bed right after lunch and no one had come back to help her. R811 said, I've had my call light on for hours. Someone comes in turns the light off and says they will come back to put me in bed, but no one has done it. So, I keep putting my call light back on. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:30 PM RN B entered the resident's room, turned the call light off. RN B returned with linen and made the resident's bed. RN B said she would get another staff person to assist the resident back to bed. The call light remained off. The resident was observed to be assisted back to bed at approximately 2:45 PM. According to R811's EHR the resident admitted to the facility on [DATE] with multiple diagnoses that included Down's syndrome and a fall with fracture to the upper extremity. A Minimum Data Set (MDS) dated [DATE] indicated R811 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15/15, had impairment to one side of the upper extremity, and required substantial to moderate assistance for mobility. Resident 812 On 6/5/24 at 2:15 PM R812's call light remained on. R812 was lying in bed and said she needed the bedpan immediately. I've had the call light on for a long time. They are very slow to answer the call lights here. I usually just give up and go in the bed, but I'm really trying to hold it until someone comes and answers my light. You should be here at night. They never answer the call light. At 2:33 PM RN B came into the room turned the call light off and then left the room without putting the resident on the bedpan. RN B said she was going to get a Certified Nursing Assistant to help place the resident on the bed pan. The resident was observed to be assisted with placement on the bed pan at approximately 2:40 PM by a CNA. According to R812's EHR the resident admitted to the facility on [DATE] with multiple diagnoses that included fall with fracture to the lower extremity. A MDS dated [DATE] indicated R812 had intact cognition with a BIMS score of 14/15 and required extensive assistance from staff for all mobility, including rolling side to side. On 6/5/24 at approximately 2:40 PM RN B confirmed she was the nurse unit manager for A/B hall and was asked about staffing for the day shift on A/B hall. RN B reported there were three Certified Nursing Assistants (CNAs) scheduled on the A/B hall for the day shift and that was 'normal staffing'. When asked why the nurse manager had answered most of the call lights by herself she said, The CNAs are all busy. We all answer call lights. RN B did not explain why she turned the call lights off before she met the resident's needs. Resident 805 On 6/5/24 at 2:48 PM the resident was observed in her room seated in her wheelchair. R805 said she called the SA to file a complaint because she had to wait over two hours for someone to answer her call light on 5/14/24 and 5/15/24. R805 said, I was swimming in pee and in severe pain. R805 said she had resorted to calling '911' on her cell phone because no one had answered her call light for over two hours on the night shift. R805 reported the police came to the facility but did not transport her to the hospital because the nurse had given her a pain pill prior to their arrival. According to R805's EHR the resident admitted to the facility on [DATE] with multiple diagnoses that included chronic pain. A MDS dated [DATE] indicated R805 had intact cognition with a BIMS score of 12/15, had impairment to both sides of the lower extremities and required extensive assistance from staff for all mobility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 6/7/24 approximately 11:00 AM she said that all staff were responsible to answer the call lights and staff should leave the call light on until the resident's needs were met. According to the facility's 'Call Light Accessibility and Timely Response' dated 8/16/2023 reads in part: - Staff members who see or hear an activated call light are responsible for responding, regardless of their assignment. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Process: . - Turn off the call light when the resident's request is met.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI0014232. Based on interview and record review the facility failed to ensure information for transfer was communicated to the receiving hospital for one (R802) of two residents reviewed for discharges and transfers resulting in the receiving hospital being potentially unaware of the resident's reason for transfer, current medical treatments or allergies along with the resident's care needs to be unmet. Findings include: According to R802's closed Electronic Health Record (EHR) the resident admitted to the facility on [DATE] for multiple diagnoses that included dementia and history of a fall with fractured Tibia (shin bone). A Minimum Data Set (MDS) dated [DATE] indicated the resident had severe cognition impairment with a Brief Interview for Mental Status score of 4/15 and required substantial to maximum assistance from staff for all mobility including sit-to-stand. A progress note On 4/26/24 at 2:46 PM reported that R802 was observed on the floor with a skin tear to the right elbow. The Physician ordered the resident to be sent out to the hospital. There were no additional progress notes or transfer forms regarding R802's transfer to the hospital. On 6/6/24 at 3:30 PM, the Director of Nursing (DON) reviewed R802's EHR and confirmed there was no transfer form or progress notes regarding the resident's transfer to the hospital on 4/26/24 at approximately 2:46 PM. The DON could not provide documentation to support the receiving hospital had received any information about the resident's transfer. The DON said, The nurse should have completed a transfer form. There isn't one here. According to the facility's Transfers and Discharges policy last revised 11/3/23 in part: The purpose of this policy is to provide guidelines for the safe transfer and discharge of a resident across the continuums of care. Transfer to Acute Care Facility: Complete the hospital transfer form assessment in PCC (PointClickCare is the facility's software program for the resident's EHR), print and send a copy with the resident which includes but may not be limited to: o Contact information of the practitioner who was responsible for the care of the resident. o Resident representative information, including contact information. o Advance directive information. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs. o Diagnoses and allergies. o Most recent relevant labs, other diagnostic tests, and recent immunizations. o All special instructions and/or precautions for ongoing care, as appropriate such as: Treatments and devices (oxygen, implants, IVs, tubes/catheters). Transmission-based precautions such as contact, droplet, or airborne. Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intakes: MI00144232, MI00144376, and MI00144868. Based on interview and record review the facility failed to implement fall interventions for three (R802, R807, and R809) of seven residents reviewed for falls resulting in all three residents not having initial fall risk assessments completed in a timely manner and all three residents sustaining falls without injury. Findings include: Resident 802 According to R802's closed Electronic Health Record (EHR) the resident admitted to the facility on [DATE] for multiple diagnoses that included dementia and history of a fall with fractured Tibia (shin bone). A Minimum Data Set (MDS) dated [DATE] indicated the resident had severe cognition impairment with a Brief Interview for Mental Status (BIMS) score of 4/15 and required substantial to maximum assistance from staff for all mobility including sit-to-stand. The MDS identified 'falls' as a triggered care area. There was no fall risk assessment including a fall risk score completed for the resident. A progress note on 4/26/24 at 2:46 PM reported that R802 was observed on the floor with a skin tear to the right elbow. There was no fall risk assessment completed for the resident at the time of the fall. On 4/26/24 at 11:41 PM (approximately 9 hours later) a progress noted documented that R802 was observed on the floor with a laceration to the right eyebrow. The physician ordered R802 to be sent out to the hospital and the resident did not return. Resident 807 According to R807's EHR, the resident admitted to the facility on [DATE] with multiple diagnoses that included aftercare following joint replacement surgery. A MDS dated [DATE] indicated the resident had intact cognition and required partial to moderate assistance from staff for all mobility including sit-to-stand. The MDS identified 'falls' as a triggered care area. There was no fall risk assessment that included a fall risk score completed for the resident. A progress note on 6/4/24 at 6:00 PM reported that R807 was observed on the floor on her back. An assessment was completed and no injuries were noted. Resident 809 According to R809's EHR, the resident admitted to the facility on [DATE] with multiple diagnoses that included dementia and history of a fall with fractured lumbar vertebra. A MDS dated [DATE] indicated the resident had moderately impaired cognition and required substantial to maximum assistance from staff for all mobility including sit-to-stand. The MDS identified 'falls' as a triggered care area. There was no fall risk assessment that included a fall risk score completed for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note on 5/9/24 at 7:51 AM reported that R809 was observed on the floor in front of her bathroom door. An assessment was completed and no injuries were noted. On 6/6/24 at approximately 3:30 PM the Director of Nursing (DON) was interviewed regarding the falls for R802, R807, and R809. The DON reviewed all three resident's EHR (R802, R807, or R809) and confirmed that no fall risk assessments had been conducted within the 24 hours of the resident's admission or prior to any of their falls. The DON provided the facility's Fall Risk/Injury Prevention policy. According to the facility's Fall Risk/Injury Prevention policy last revised on 10/2021 in part: It is the policy of this facility to assess every resident for fall risk and provide an environment that is free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. A Fall Risk assessment will be completed on every patient entering the facility within 24 hours of admission or readmission. This assessment tool is to be completed with the initial nursing and/or therapy assessment. The tool will also be completed at least quarterly and with a significant change in condition. Policy Explanation and Compliance Guidelines: 1.The fall risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified. PROCEDURE: 1. The scores within the assessment will be tallied. A score of >10 represents an increased risk of falls. The IDT team, with its discretion, may add interventions to any patient they deem at risk for falls/ injury.