STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235376	A. Building B. Wing	09/05/2024

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 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** 22349 This citation pertains to intake MI00146645. Based on interview and record review, the facility failed to develop or implement a care plan for anticoagulant administration (warfarin, a blood thinner) for two (R801 and R802) of three residents reviewed for care plans resulting in R801 and R802 not having a care plan for monitoring anticoagulation therapy side effects and the potential for healthcare needs to go unmet. Findings include: The State Agency received a complaint that the facility did not monitor a resident that was receiving warfarin for anticoagulation therapy side effects. R801: According to the Electronic Health Record (EHR) R801 admitted to the facility on [DATE] with diagnoses that included history of pulmonary embolism (blood clot in the lungs). On 8/1/24 the physician ordered warfarin 7. 5 mg (milligrams) daily at bedtime. The order summary for warfarin included a black box warning (the strictest and most serious type of warning that the FDA gives a medication that alerts consumers when a serious adverse or special problem occurs, particularly those that may led to death or serious injury) that indicated warfarin can cause major or fatal bleeding. The physician ordered to review the warfarin flowsheet every nightshift in assessments. The flowsheet included information to monitor the use of warfarin administration and anticoagulation therapy. The Minimum Data Set (MDS) dated [DATE] indicated that R801 was receiving anticoagulant medication daily. A review of the resident's care plans revealed there was no care plan or interventions for monitoring the side effects for the risk of bleeding due to warfarin administration or anticoagulation therapy. On 9/5/24 at 1:30 PM the Director of Nursing (DON) acknowledged that R801 did not have any care plan or interventions regarding the use of warfarin or anticoagulation therapy. The DON said the facility did not have any policy specifically for the use of anticoagulants. The policy for care plan implementation was requested. R802: (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the R802's EHR the resident admitted to the facility on [DATE] with diagnoses that included history of Atrial Fibrillation (A-fib, irregular rapid heart beat that commonly causes poor blood flow and blood clot formation). The resident was prescribed warfarin 12.0 mg daily at bedtime. The order summary for warfarin included a black box warning. The physician ordered to review warfarin flowsheet every nightshift in assessments. The Minimum Data Set (MDS) dated [DATE] indicated that R802 was receiving anticoagulant medication daily. A review of the resident's care plans revealed there was no care plan or interventions for monitoring the side effects for the risk of bleeding due to warfarin administration or anticoagulation therapy. On 9/5/24 at approximately 4:15 PM the DON acknowledged that R802 did not have a care plan for the use of anticoagulants. According to the facility's Care Plan policy last revised on 8/25/23, read in part: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 This citation pertains to intake MI00146645. Based on interview and record review, the facility failed to maintain complete and accurate medical records for one (R801) of three residents reviewed for medical records, resulting in R801's INR results not accurately documented or maintained in the resident's Electronic Health Record (EHR) resulting in the potential for an unclear picture of the resident's blood clotting times and health care needs. Findings include: The State Agency received a complaint that the facility did not monitor a resident that was receiving warfarin for anticoagulation therapy side effects. R801: According to the Electronic Health Record (EHR) R801 admitted to the facility on [DATE] with diagnoses that included history of pulmonary embolism (blood clot in the lungs). On 8/1/24 the physician ordered warfarin 7. 5 mg (milligrams) daily at bedtime. The order summary for warfarin included a black box warning (the strictest and most serious type of warning that the FDA gives a medication that alerts consumers when a serious adverse or special problem occurs, particularly those that may led to death or serious injury). The black box warning indicated that warfarin can cause major or fatal bleeding. The physician ordered to review the Warfarin Flowsheet every nightshift in assessments. The Warfarin Flowsheet included the resident's INR results. An INR blood test is used to monitor clotting times in people taking warfarin to check how well your blood clots. A normal INR range is 0.8 to 1.1 if you're not taking anticoagulant medications such as warfarin. R801's Medication Administration Record (MAR) reflected the order and had the following documentation: Review Warfarin Flowsheet every night shift. Must be reviewed and updated daily. R801's EHR only had one completed Warfarin Flowsheet dated on 8/8/24. On 8/8/24 the INR was 1.98. On 9/5/24 at 1:30 PM the Director of Nursing (DON) acknowledged that R801 only had one completed Warfarin Flowsheet in their EHR. The DON said, We realized that we did not completely document all the resident's INR results in the Warfarin Flowsheet. We immediately did an education for all the nurses. We did complete INR tests for the resident but did not document all of them correctly in the medical record. At this time the DON produced two additional INR lab results for R801 that were not part of the resident's EHR. The DON acknowledged that R801's INR lab results were not in the resident's EHR. The DON said, I got the INR results from the lab. They faxed it over today. On 7/31/24, R801 had an INR lab result of 2.78. This result was documented on the MAR. There was no corresponding Warfarin Flowsheet. On 8/5/24, R801 had an INR lab result of 1.98. This result was not documented on the MAR and there was no corresponding Warfarin Flowsheet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 8:00 AM during a phone interview, the physician said the resident did not have the Warfarin Flowsheets up-to-date but that the INR blood tests were being done and reviewed through the lab. According to the facility's Lab Results policy last revised on 8/18/23, in part reads: The facility must provide or obtain laboratory services when ordered * For facilities and laboratories integrated with the electronic health record PointClickCare (PCC), laboratory results will display in PCC under the resident ' s results tab, and unreviewed laboratory results can also be accessed under the Clinical Dashboard and under the Clinical Lab/Rx Results Dashboard in PCC. * For facilities and laboratories not integrated with electronic health record PointClickCare (PCC), laboratory results may be faxed to the facility or retrieved from the laboratory's website. Those results will be uploaded into the resident ' s electronic health record in PCC under the documents tab.