| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235396 | A. Building<br>B. Wing | 05/08/2024 |

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| The Villa at Silverbell Estates | 1255 W Silverbell Rd<br>Orion, MI 48359 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208<br><br>Based on observation, interview, and record review, the facility failed to ensure treatment in a dignified manner for seven residents (R#s 5, 42, 66, 13, 7, 55, and 289) of seven residents reviewed for dignity. Findings include:<br><br>A review of a facility provided policy titled, Resident Rights, dated 11/2017 was reviewed and read, .The right to be treated with respect and dignity .<br><br>On 5/6/24 at 10:00 AM, an interview was being conducted with R5 in their room with the door closed. During the interview, Certified Nurse Aide (CNA) 'B' entered the room without knocking or asking permission to enter. At approximately 10:05 AM, observations from the hallway revealed CNA 'B' entering R42 and R66's room retrieving breakfast trays. CNA 'B' was not observed to knock on the door and ask permission for entry. Upon exiting the room CNA 'B' was then observed to enter several other rooms on the hallway collecting breakfast trays without knocking or asking permission for entry to the rooms.<br><br>On 5/6/24 at 10:10 AM, an interview was conducted with R13 in their room with the door closed. During the interview, CNA 'B' entered the room without knocking or asking permission to enter.<br><br>On 5/6/24 at 12:37 PM, an overhead page throughout the facility announced the, Feeder Cart (lunch cart) had been delivered to the unit.<br><br>On 5/6/24 at 12:43 PM, a lunch cart was observed being delivered to the unit. CNA 'E' received the cart from the dietary staff member and was overheard asking if the cart delivered was for, The Feeders.<br><br>On 5/7/24 at approximately 12:30 PM, CNA 'D' was observed to be standing and feeding R7 their lunch meal in their room. At approximately 12:45 PM, CNA 'D' was then observed to be standing and feeding R55 their lunch meal in their room.<br><br>On 5/7/24 at 1:09 PM, upon entry to R66's room, Nurse 'C' was observed from the hallway to be seated in a lounge chair in the room engaging with and scrolling on their cell phone while R66 sat in their bed and ate their lunch meal.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of an untitled facility provided document was reviewed and read, .Do not use devices during working time or while on Company premises that obstruct or restrict your hearing (such as cell phones . iPhones, and other similar devices), except for cell phone use authorized by management.<br><br>On 5/8/24 at approximately 3:20 PM, an interview was conducted with the facility's Administrator regarding concerns identified with dignity. The Administrator acknowledged the concerns.<br><br>48680<br><br>R289<br><br>On 5/7/24 at 10:19AM, R289 was observed in their room lying down in bed, a bulging bag was observed to be protruding from under their gown. R289 was asked how they enjoyed their care at the facility, R289 stated that the facility was nice and better than the one they had previously come from. R289 was then asked why they kept a plastic bag underneath their gown, R289 stated because their colostomy bag leaks if the stool is watery, and it gets on the skin and runs on the bed so they put a towel and plastic bag over it. R289 was asked did they request it be dressed like that, R289 stated no, the nurse did it like that and gave them the stuff so it wouldn't leak.<br><br>A record review revealed that R289 was admitted to the facility on [DATE] with a diagnosis of Colostomy status, type 2 diabetes, and adjustment disorder with mixed anxiety and depressed mood. R289 had a brief interview for mental status score of 10, indicating a moderately impaired cognition.<br><br>On 5/8/24 at 8:30AM, an observation of R289's colostomy was made. It was still dressed in a plastic bag with towels wrapped around it. R289 stated that the nurse gave them new towels and a plastic bag.<br><br>On 5/8/24 at 10:00AM, the Director of nursing (DON) was interviewed and asked what the protocol was for colostomy care. The DON explained that there should be an order for monitoring, the certified nursing assistant (CNA) can care for them and empty them out and that there should be orders in for signs of infection skin. The DON was asked had she observed the colostomy for R289 and the DON stated they had not yet. The DON was then asked is it appropriate to have a colostomy wrapped in a plastic bag and towel to prevent it from leaking. The DON stated No and explained that she would go assess the situation. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208<br><br>Based on interview, and record review, the facility failed to coordinate a transfer to the hospital per the resident's choice for one resident, (R35) of two residents reviewed for choices, resulting in R35 feeling the facility did not take their health condition seriously. Findings include:<br><br>On 5/6/24 at 11:05 AM, an interview was conducted with R35. R35 said an incident occurred in March (2024) where they were not feeling well and requested to go to the emergency room . R35 said they were pretty sure they had pneumonia and needed antibiotics. They further indicated staff told them they didn't need to go out and a transfer was not coordinated per their request. R35 reported they called 911 themselves and went to the emergency room where they were diagnosed with pneumonia and received intravenous (IV) antibiotics.<br><br>R35's clinical record was reviewed and revealed they originally admitted to the facility 11/23/22, and most recently readmitted on [DATE] with diagnoses that included: multiple sclerosis, paraplegia, chronic obstructive pulmonary disease, and pneumonia (added as a diagnosis after their re-admission to the facility on [DATE]). R35's most recent Minimum Data Set assessment indicated R35 had intact cognition, was non-ambulatory, and needed assistance from staff for most activities of daily living.<br><br>A review of a progress note entered into the record by Nurse 'A' on 3/23/2024 at 8:05 PM, read, .Writer notified that resident c/o (complained of) cough and not feeling well. Vitals are all stable .LPN (Licensed Practical Nurse) educated resident that NP (Nurse Practitioner) assessed resident on Wednesday 3/20/24 and ordered cough syrup and allergy medications .Resident was educated that her c/o's (complaints) were not emergent and there was no reason to call 911 and go to the hospital at this time. Will Continue to follow POC (plan of care) .<br><br>A review of R35's vital signs in the clinical record were reviewed and revealed the last documented vital signs on 3/23/24 were documented at 10:58 AM, approximately 9 hours prior to R35 requesting a transfer to the emergency room .<br><br>On 5/6/24 at 3:52 PM, a review of R35's hospital record for their admission on 3/23/24 was reviewed and read, .Chief Complain: .Cough. Yellow green sputum when coughing. SOB (shortness of breath, chills . started a week ago. Low grade fever. Hx (history) of pneumonia in the past .HISTORY OF PRESENT ILLNESS . In the ED (Emergency Department) she was febrile with a temperature of 100.4 .Patient's SpO2 (blood oxygen level) dropped down to 86% and was placed on 2 L (liters) supplemental oxygen .Assessment & Plan: Acute hypoxic respiratory failure .Final diagnoses: Pneumonia of right lower lobe due to infectious organism . Further review of R35's hospital records revealed they were admitted to inpatient from the emergency room and were treated with antibiotic therapies.<br><br>On 5/7/24 at 2:27 PM, an interview was conducted with Nurse 'A' asking about R35's request to go to the emergency roiagnom on [DATE]. Nurse 'A' said R35 was non-emergent. Nurse 'A' said R35, Wasn't told she couldn't go. When asked why the facility did not facilitate the transfer per the resident's request and asked why R35 called 911, Nurse 'A' had no explanation.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/7/24 at 3:53 PM, an interview was conducted with the facility's Director of Nursing (DON). The DON said the facility, Did not stop R35 from going to the emergency room . The DON said R35 called 911 and went to the emergency room . When asked why the facility did not coordinate a transfer for the resident per their request the DON said, she was non-emergent and they don't waste resources because she was not in distress. The DON further said, R35, did not give us any time.<br><br>A review of a facility provided policy titled, Resident Rights dated 11/2017 was reviewed and read, .The right to reasonable accommodation of needs so long as it doesn't endanger the health or safety of you or other residents . |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680<br><br>Based on interview and record review the facility failed to ensure correct and completed involuntary discharge transfer documents for one resident of one resident reviewed for discharge.<br><br>Findings include:<br><br>On 5/6/24 at 10:48AM, R58 was observed in their room watching television. R58 was interviewed about the care received while in the facility. R58 stated that the facility was involuntarily discharging them due to a small bottle of unopened whiskey they found in the resident's nightstand. R58 was then asked how many times were they warned or educated on the matter of having alcohol in the facility. R58 stated this was the second time they were caught with an unopened bottle. R58 stated that they were allowed to go on leave of absences(LOA). R58 stated that the facility told them that they had a month to find new living arrangements.<br><br>A record review revealed that R58 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease, chronic respiratory failure and acquired absence of toes. R58 had a brief interview for mental status score of 15, indicating an intact cognition.<br><br>On 5/8/24 at 9:05AM ,the Admissions and Social Services Director(SSD), was interviewed and asked who is responsible for discharge planning (involuntary, voluntary, and nonpayment). The SSD replied the business office would handle nonpayment issues and anything else, the SSD does. The SSD was then asked, what does an involuntary discharge include and replied that she receives details from the department and prints off the paperwork with the appeal. The SSD goes over it with the resident and helps them fill out the appeal if they need assistance, and faxes it off for them. With the involuntary discharge paper work. the SSD emails it to the appropriate place and adds the administrator to that reference. The SSD was then asked why was R58 being involuntary discharged . The SSD explained that R58 had aggressive behaviors and it was a safety issue for themselves, residents and staff. The SSD was asked where the documentation is stating the aggressive, unsafe behaviors and how many times he was educated and approached (with bad behavior). The SSD replied , I don't do the progress notes it would be up to nursing or whatever complaining department.<br><br>On 5/8/24 at 11:00 AM Director of Nursing (DON) was interviewed and asked why was R58 being involuntarily discharged , the DON replied that R58 drinks when on LOA and it's unsafe to care for them medically when they (the facility) don't know what their actually doing or consuming. The DON was then asked , where is the supporting documentation stating that R58 has been educated, talked too or warned about these alleged behaviors. A chart review for progress notes was conducted with the DON and nothing was found.<br><br>No additional information was provided by the exit of survey. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>34208<br><br>Based on observation, interview, and record review, the facility failed to ensure X-rays were ordered in a timely manner after a fall for one resident (R32) of one resident reviewed for diagnostic testing. Findings include:<br><br>On 5/6/24 at 1:16 PM, R32 was observed in their room in their wheelchair. They were asked about their stay in the facility and said they had a fall last night. They said they hurt their left arm and their left leg. An observation of their right arm revealed it was slightly reddened in comparison to their left.<br><br>On 5/6/24 at 1:44 PM, a review of a progress notes entered into the record by Nurse 'H' revealed the following:<br><br>5/6/24 6:35 AM, .Upon Morning medication pass resident is found behind door on floor next to W/C (wheelchair) on L (left) side of body in fetal position. Resident is alert and inquiring who moved her Blankets and pillow .Resident c/o (complains of) pain in LUE (Left Upper Extremity) w/ (with) 10/10 pain & LLE (Left Lower Extremity) w/ 9/10 pain .<br><br>5/6/2024 at 7:23 AM, .On call per (Doctor's Name) Group paged r/t (related to) office closed .<br><br>5/6/2024 at 7:38 AM, .Log placed in physicians book to evaluate upon daily rounding. Unable to contact via phone/message multiple numbers rejected r/t after-hours .<br><br>On 5/6/24 at 4:00 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R32's fall. They said they were aware of the fall, but R32 refused assessment, pain medication, and, Refused to have X-rays ordered at the time of the incident. They were asked how a resident can refuse just an order for an X-ray, it would be understandable for a resident to refuse the actual X-ray test, but they had no explanation.<br><br>A review of a late entry progress note entered into the record at 7:00 PM for 3:55 PM, read, Resident agreed to post fall assessment & skin evaluation @ (at) this time. Resident c/o of pain with movement to L Lower Arm , posterior arm observed to have an abrasion no drainage noted. Received v.o (verbal order) from N.P for X -Ray .<br><br>A review of R32's orders was conducted and revealed X-rays were not ordered until the afternoon of 5/6/24, despite Nurse 'H's note at the time of the incident (6:35 AM) documenting R32's pain level of nine out of ten for their lower extremity and a ten out of ten for their upper extremity.<br><br>A review of facility policies regarding falls and diagnostic testing were reviewed, however; neither policy addressed the facility's responsibility to order X-rays in a timely manner. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271<br><br>Based on observation, interview and record review the facility failed to ensure appropriate vision care was provided for one resident (R21) of one resident reviewed for vision/hearing. Findings include:<br><br>On 5/06/24 at approximately 11:08 a.m., R21 was observed up in their wheelchair in the dining room. R21 was queried if they had any concerns regarding their care and they reported they had difficulty with their vision and the facility was not helping them with it.<br><br>On 5/7/24 at approximately 3:19 p.m., R21 was observed in their room, sitting up in their bed. R21 was asked if they were able to see other objects and they indicated they can only see straight but nothing on the sides (peripheral vision), they again reported they felt the facility has not helped them with their vision.<br><br>On 5/6/24 the medical record for R21 was reviewed and revealed the following: R21 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Legal blindness. A review of R21's MDS (Minimum Data Set) with an ARD (assessment reference date) of 4/25/24 documented R21 had severely impaired vision.<br><br>An Optometry evaluation order form dated 3/6/24 titled Optometry Order Form revealed the following: Referrals: Refer to ophthalmologist for cataract surgery of rt (right) eye Other: Warm compress and wash lids with baby shampoo QD (every day) bid (three times a day) for blepharitis (recommend on shower days) .<br><br>A health status note dated 3/6/24 revealed the following: Resident had visit with (eye care contract company) and received a referral for cataract surgery in his right eye. Resident to have an appointment scheduled with ophthalmologist. Will continue with POC (plan of care).<br><br>Further review of the medical record did not reveal any orders or directions for the warm compresses to be applied to R21's eye lids per the optometry order form, nor were there any risk verse benefits statements from the attending Physician to indicate they had reviewed the order for the warm compress to R21's eye lids.<br><br>On 5/8/24 at approximately 9:46 a.m., during a conversation with social service worker F (SS F), SS F was queried regarding R21's optometry visit dated 3/6/24 and they reported that R21 did have a cataract surgery appointment but reported the Nursing Department would do the warm compress to R21's eye lids.<br><br>On 5/8/24 at approximately 10:45 a.m., Nurse Manager G (NM G) was queried regarding the lack of documentation for R21's compresses to their eye lids and reported they would have to look into it.<br><br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/8/24 at approximately 11:20 a.m., during a follow-up conversation with NM G, NM G indicated that R21's cataract appointment was addressed but they had no documentation that any follow-up pertaining to the application of the warm compresses to R21 eye lids was available. At that time, a request for any further documentation pertaining to the warm compresses ordered for R21 was requested but none was received by the end of the survey.<br><br>On 5/8/24 a facility document pertaining to vision services and treatment was reviewed and revealed the following: Purpose: To ensure residents receive proper treatment and assistive devices to maintain vision and hearing abilities .Treatment and Devices to Maintain Hearing and Vision Guideline .Our facility, to ensure our residents receive proper treatment and assistive devices to maintain vision and hearing provide the following support . |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271<br><br>Based on observation, interview and record review the facility failed to ensure Physician's orders were followed for oxygen therapy administration for two residents (R58 and R63) of two residents reviewed for respiratory care. Findings include:<br><br>On 5/6/24 at approximately 1:01 p.m., R63 was observed in their room, laying in their bed. R63 was observe to have oxygen delivered via nasal cannula at 1.5 liters per minute (LPM). R63 was queried if they knew how many liters per minute of oxygen they should be on and they reported it should be at three liters.<br><br>On 5/6/24 at approximately 3:58 p.m., R63 was observed in their room, laying in their bed with oxygen still being delivered via nasal cannula at 1.5 LPM.<br><br>On 5/6/24 the medical record for R63 was reviewed and revealed the following: R63 was initially admitted to the facility on [DATE] and had diagnoses including Chronic obstructive pulmonary disease (COPD) and pulmonary collapse. A review of R63's MDS (Minimum Data Set) with an ARD (assessment reference date) of 2/18/24 revealed R63 was on oxygen therapy. R63's BIMS score (brief interview for mental status) was 12 indicating moderately impaired cognition.<br><br>A Physician's order dated 4/24/24 revealed the following: Continuous O2 (oxygen) Via (NC/MASK) at 3 lpm as tolerated every shift<br><br>A Nurse Practitioner evaluation dated 4/25/24 revealed the following: Chronic obstructive pulmonary disease, unspecified COPD type Stable Chronic Resident seen by [Physician] 7/2023. Resident placed on Trelegy (COPD medication) Return if difficulties. CT (computed tomography) shows no active disease. Utilizing supplemental oxygen 3 liters with measured pulse ox of 97%. Lungs . no adventitious sounds or accessory muscle use Encourage resident to wear supplemental oxygen pt (patient) to be on 3LPM at all times .<br><br>On 5/7/24 at approximately 4:07 p.m., R63 was observed in their room, laying in their bed with their nasal cannula delivering oxygen with Unit Manager G (UM G). UM G was queried what the oxygen settings for R63's oxygen administration were currently set at and they reported that it was 1.5 LPM. R63 then reported that they should be on 3 LPM and UM G indicated they would have to verify the Physician's order.<br><br>On 5/7/24 at approximately 4:11 p.m., UM G reported that they had verified R63's oxygen order and that it should be at 3 LPM. UM G indicated they had modified the settings for R63 to provide them the ordered 3 LPM.<br><br>48680<br><br>R58<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/6/24 at 10:48AM, R58 was observed in their room watching television, R58 had a oxygen concentrator in their room and it was set for 5 Liters and had humidification water bottle connected which was resting on the ground. R58 was then asked was the humidification bottle to their oxygen always on the ground, R58 replied yes and explained that sometimes they get a rush of water that goes up their nose because someone would knock it over and not pick it up. R58 further explained that when that happened, they would have to remove their oxygen off for about five minutes so the water could drip out of the line.<br><br>A record review revealed that R58 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease, chronic respiratory failure and acquired absence of toes with a brief interview for mental stats score of 15, indicating an intact cognition.<br><br>On 5/7/24 at 9AM, an observation of R58's humidification bottle was made and it was located on the floor in room in the same area. R58 was asked how often the facility changed the tubing on the oxygen equipment, R58 stated weekly on Wednesdays.<br><br>On 5/8/24 at 10:15 AM, an observation was made of R58's oxygen humidification, and it was located inside the resident's shoe.<br><br>On 5/8/24 at 11:00 AM the company that changes the respiratory equipment was present and was asked if they change out the humidification bottles and explained the nurses are responsible for that and the company just changed out the nasal cannulas and nebulizer mask.<br><br>On 5/8/24 at 11:10 AM, CNA M was interviewed and asked if the oxygen humidification bottle should be located on the ground. CNA M replied, No. CNA M was asked if R58's humidification bottle should be stored in their shoe, CNA M replied, No and went to get the nurse.<br><br>On 5/8/24 at 11:30 AM, Unit manager G was interviewed about the humidification bottle being located on the ground, Unit manager G stated that they would assess the situation.<br><br>On 5/8/24 at 1:00PM, R58 was asked did they know how many liters of oxygen were they placed on R58 stated, 5Liters. According to the order in electronic health record, R58 had an order for 3Liters. R58 clarified that the 3 liters was an old order and that they needed more than 3 liters now.<br><br>No addition information was provide at the exit of this survey. |

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| | 235396 | A. Building<br>B. Wing | 05/08/2024 |

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| The Villa at Silverbell Estates | 1255 W Silverbell Rd<br>Orion, MI 48359 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680<br><br>Based on observation, interview, and record review, the facility failed to provide pain management services for two of two residents (Resident 84 and 290 ) reviewed for pain, resulting in unrelieved pain. Findings include:<br><br>R209<br><br>On 5/6/24 at 9:18AM, R290 was observed laying on their back watching television. R290 was asked how their care was at the facility. R290 stated it was okay and explained that have only been here for a couple of days because they broke their arm. R290 further explained that they were in a lot of pain and the facility took their walker and now had to hold the side of the wall to walk down the hallway. R290 was asked what they received for pain stated, Nothing, in the hospital I was getting morphine and oxycodone, then I got here and I don't even get an aspirin.<br><br>A record review revealed that R290 was admitted to the facility on [DATE] with the diagnosis of displaced fracture of surgical neck of left humerus, chronic obstructive pulmonary disease, and muscle weakness. A further review of the record revealed that R290's hospital paper work revealed R290 was receiving oxycodone as needed every four hours, morphine as needed every four hours, and Tylenol for pain.<br><br>On 5/8/24 at 11:00AM an interview with the Director of Nursing (DON) was conducted and asked, what medication orders get put in the system when someone comes from the hospital. The DON explained they followed the hospital discharge summary. The DON was asked why R290 did not have anything for pain ordered and replied that R290 didn't have an script for narcotics and upon the nurses initial assessment, R290 did not complain of pain. The DON was then asked how a person who received pain medications in the hospital would receive medications for pain once admitted to the facility. The DON explained that an order for Tylenol or something of that strength could be provided until the provider can assess the resident. The DON further explained that it was not reported that R290 was in any pain. DON stated she would follow up with R290 in regard to their pain level.<br><br>A record review and interview revealed that R290 was admitted to the facility on Friday 5/3/24 and stated the entire weekend they were in pain because at the time of the initial assessment R290 didn't state a pain level.<br><br>R84<br><br>On 5/6/24 at 9:48AM, R84 was observed lying in the bed watching television. R84 was interviewed and asked how the care was they received at the facility, R84 replied, It's okay, but I am a very sick person. I have cancer to the bone and live in excruciating pain. R84 was asked how did the facility manage their pain, R84 replied they don't, they get pain medication when the facility feels like giving it to them. R84 stated that they receive Norco and morphine but it takes the nurses forever to bring the morphine.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review revealed that R84 was admitted to the facility on [DATE] with the diagnosis of Malignant neoplasm of lung, Malignant neoplasm of the bone and anemia. A further review of the record revealed that R84 had an as needed order for morphine every three hours, and the last dose was given on May 4th 2024 and prior to that day, April 30th 2024 (according to the narcotic sheet).<br><br>On 5/8/23 at 1:00PM, the Director of nursing (DON) was interviewed and asked why didn't R84 receive an as need dose of medication when needed. The DON explained that R84 can get medication when ever they asked for it but the resident often refuses medications but she would look into the situation.<br><br>On 5/8/24 at 1:20PM R84 was asked if they refuse pain medications, R84 explained that they refused medications like stool softeners or medications of that nature but I never pain medications.<br><br>No additional information was provided by the exit of survey |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>38271<br><br>This citation pertains to intake#MI00144094.<br><br>Based on interview and record review, the facility failed to ensure sufficient nursing staff were provided to meet resident needs for three residents (R58) and two other residents (who preferred to remain anonymous), potentially affecting all 87 residents residing in the facility. Findings include:<br><br>On 5/6/24 a review of the payroll based journal report (PBJ-A total of Nursing hours worked reported by the facility to the Center for Medicare and Medicaid Services) was conducted and revealed the facility had excessively low weekend staffing hours during FY (fiscal year) Quarter one (October through December 2023).<br><br>On 5/7/24 at 10:30 a.m., during the anonymous group meeting, two residents indicated the facility was short staffed, they had to wait a long time for call light responses on the weekend shifts, and the (meal) tray pass was slow due to not enough Nursing aides to help pass the trays timely. One resident indicated that there were times when only one Nursing aide is passing trays at a time which resulted in cold food being served.<br><br>On 5/08/24 at approximately 1:42 p.m., during a discussion with Staffing Coordinator I (SC I), SC I was queried if the facility had been short staffed on the weekends as indicated by the PBJ report and they said they had been, and it was due to the amount of call offs that staff were doing. SC I was queried if they had been aware of resident concerns about missed showers and longer call light response times and they indicated they were, and they were trying to get more staff in the facility. SC I indicated Sundays were the hardest to staff and that may have been why they triggered to excessively low weekend staffing. SC I indicated they use staffing agencies for Nurses but not for Nursing aides so they have days where they cannot fill the assignments and run short. SC I was queried regarding the minimum of CNA's required for each shift and they reported that it was eight on day shift, eight on afternoons and 5 on the nightshift. The weekend staffing levels for February, March April and May were reviewed and revealed the following days in which the staffing levels were below SC I's reported minimums. 2/11 (Sunday), 2/25 (Sunday), 3/9 (Sunday) , 3/10 (Monday), 3/31 (Sunday), 4/13 (Saturday), 4/21 (Sunday) and on 5/6 (Monday). SC I reported that they have had multiple problems with filling the Sundays/weekend shifts and that they have been offering bonuses for staff to pick up shifts.<br><br>On 5/8/24 at approximately 3:04 p.m.,, R58 was observed in their room, laying in their bed and reported that they had concerns about the amount of staff working in the facility. R58 indicated they had an issue with getting their hair washed. R58 said the facility only bathes them twice a week and that they have wanted more bathing than that at times, but staff have told them that it wasn't their day to shower and they were short staffed.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/08/24 at approximately 3:18 p.m., during a conversation with Certified Nursing Assistant J (CNA J) they were queried regarding the staffing levels on the weekends. CNA J indicated weekends are worse than weekdays and the facility does run short of staff on the weekends at times. CNA J indicated they have to prioritize with the others CNA's in keeping residents safe and dry and showers may not get completed and call lights may take longer to be answered on the weekends when they are short of staff.<br><br>On 5/8/24 a facility document pertaining to facility staffing was reviewed and revealed the following: Our facility provides adequate staffing to meet needed care and services for our resident population. 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>48680<br><br>Based on observation, interview, and record review the facility failed to maintain a medication error rate of less than five percent when three medication errors were observed and one medication not signed out from a total of 25 opportunities observed during medication administration, resulting in a medication error rate of 12%. Findings include:<br><br>On 5/7/23 at 08:39 AM Nurse O was observed during a medication administration pass for R42. Nurse O properly pulled and administered medication to resident and when exited the room, nurse O signed out the medications. Nurse O was asked if R42 received everything that they were supposed to for this medication pass. Nurse O stated, Yes.<br><br>A record review of the physician orders and Medication Administration Record (MAR) revealed that upon reconciliation Nurse O had not administered Fenofibrate 54mg, Loratadine and Sertraline 25mg, and did not sign out the as needed Tylenol that was administered.<br><br>On 5/7/24 at 11:40 AM Nurse O was interviewed and asked why didn't they administer all due medications. Nurse O replied, I did administer everything and reviewed the electronic health record and noticed the medications not given and replied, I didn't know I was to give those.<br><br>On 5/8/24 at 11:55 AM the Director of nursing (DON) was interviewed and asked what the time frame was for medications to be administered. The DON replied, we are moving to a more liberal schedule so they have a range from 7am-11am to get morning medications so it wont be on such a strict time regimen and more home like. The DON was then asked was all the nurses aware and was education provided to the staff on the liberal schedule. The DON stated they we are incorporating that into their educations since it was something new. The DON was then informed of the medication administration pass and that Nurse O was not aware to pass the medications with that labeling. DON replied that she would figure out the situation.<br><br>No additional information was provided by the exit of survey. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680<br><br>Based on observation, interview, and record review, the facility failed to ensure three insulin pens were stored in the appropriate place and two of four medication carts observed unlocked. Findings include:<br><br>On 5/6/24 at approximately 4:17 p.m., a nursing treatment/medication cart located on the Oakland hallway containing various wound care treatments/creams was observed unlocked and unattended by any nursing staff.<br><br>On 5/7/24 at 8:39 AM after Nurse O finished with a medication pass, an inspection of the cart on Oakland was made, there were three unopened insulin pens in the top drawer. Nurse O was asked where should unopened insulin be located and stated that it should be in the refrigerator.<br><br>On 5/7/24 at approximately 10 AM, a medication cart located on the [NAME] unit was observed unlocked and unattended.<br><br>On 5/7/24 at approximately 1PM, a medication cart located on the Oakland unit was observed unlocked and unattended.<br><br>On 5/8/24 at 11:00 AM the Director of Nursing (DON) was interviewed and asked should medication carts be locked and where should unopened insulin be stored. The DON replied, Yes, all carts should be locked and unopened insulin should be stored in the refrigerator.<br><br>No additional information was provided at the exit of survey.<br><br>38271 |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>34208<br><br>Based on observation, interview, and record review, the facility failed to ensure palatable meals for six residents (R#'s 66, 70, 9, 65, 35, and 10) of twelve residents reviewed for food palatability, and failed to serve food at a palatable temperature, resulting in verbalized complaints and frustration with meals. Findings include:<br><br>On 5/6/24 at 9:51 AM, R66 reported they did not get enough food with their meals and said the portions were too small. They further reported their last meal was at 7 PM the previous evening, approximately 15 hours previous. They were asked if they were offered a snack and said it was a small cookie, but they were still hungry.<br><br>On 5/6/24 at 10:27 AM, R70 was asked about the food and said, It is terrible. They further said the meats were tough and the food had an unpleasant aroma. They also reported the meats were often covered in gravy but the meats remained tough.<br><br>On 5/6/24 at 10:35 AM, R9 was observed lying in their bed. They were asked about the food and said they did not get enough food to eat with their meals.<br><br>On 5/6/24 at 10:45 AM, R65 was asked about the food and said it was, awful. They said it was often cold and recently dinner had not been served until 7 PM.<br><br>On 5/6/24 at 12:20 PM, observations of the lunch meal was conducted. It revealed a chicken breast with a yellow-orange (cheese) sauce, a baked potato that appeared dry with no sour cream (despite sour cream being on the menu), and cooked spinach that appeared slimy in texture.<br><br>On 5/6/24 at 1:08 PM, R66's lunch meal was observed. R66 had a mechanical soft texture diet. The meat had watery condensation around it making it appear mushy/soggy. It was not observed to contain the yellow/orange cheese sauce that covered the regular texture chicken. R66 was asked about the meat, and said they thought it was chicken. R66 said, It doesn't look very good. At that time, R66 was asked if they were ever given a menu to choose their meals and said no, but they would like one.<br><br>On 5/6/24 at 1:12 PM, R35 was asked about their lunch meal. The said It's gross, I'm not going to eat it. R35's meal was observed to be a chicken breast with yellow-orange sauce, a dry baked potato with no sour cream and the liquid/slimy spinach.<br><br>On 5/8/24 at 8:55 AM, an interview was conducted with R65, they were asked if they ever received a menu or knew in advance what the meals were and they said no. When asked if they would like one, they said they would, and believed a lot of other residents would as well. R65 reported residents talked among themselves asking one another what the meals were.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/8/24 at approximately 9:05 a.m., R10 was observed in their room, attempting to eat their breakfast meal. R10 indicated that they did not get any coffee or milk on their tray that morning only juice was provided. R10 reported they were upset because they had been waiting for their coffee and still did not have any. R10 also stated the toast was hard as a rock and burnt. At that time, R10's toast was observed to have 50% of the toast being dark black in color indicating it had been over toasted and burnt. A review of R10's breakfast meal ticket was observed which indicated R10 was supposed to receive 8fl (fluid) ounces of milk and Coffee with Sugar and Creamer at breakfast.<br><br>On 5/8/24 at 12:42 PM, R66's lunch meal was observed, the vegetable provided was carrots. They reported they had been served carrots two days in a row. They were asked if they were ever offered soup with their lunch meal and said they were not.<br><br>On 5/8/24 at 12:50 PM, an interview was conducted with R70, who's meal contained carrots. They were asked if they had carrots yesterday and said they did.<br><br>On 5/8/24 at 1:06 PM, an interview was conducted with the facility's dietary manager. They acknowledged concerns identified with food service and said they had been steadily working on improvement. They were asked about providing residents with a menu and said there was no menus posted and residents were not provided with menus.<br><br>On 5/8/24 a facility document pertaining to the palatability of food was reviewed and revealed the following: Standard-Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs .<br><br>38271<br><br>On 5/6/24 at 12:20 PM, residents were observed in the dining room, being served soup from a soup kettle. The internal temperature of the soup inside the kettle was measured to be 117 degrees Fahrenheit.<br><br>On 5/6/24 at 12:25 PM, when queried, Dietary Manager K looked at the kettle and stated the temperature dial needed to be adjusted to a higher temperature.<br><br>According to the 2017 FDA Food Code section 3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding. 1. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C ) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained: 1. (1) At 57 C (135 F) or above .<br><br>22960 |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>34208<br><br>Based on observation, interview, and record review, the facility failed to ensure food preferences for seven residents (R#'s 66, 35, 70, 41, 68, and 65) of 12 residents reviewed for food preferences, resulting in verbalized complaints and dissatisfaction with meals. Findings include:<br><br>On 5/6/24 at 9:51 AM, R66 was asked about the food in the facility. They said they were never served coffee. Their breakfast tray was observed and did not contain coffee. A review of R66's meal ticket revealed a liked food/drink item was coffee.<br><br>On 5/6/24 at 10:45 AM, R65 was interviewed about the food and said it was, awful. They said they frequently requested items from the always available menu but they were rarely provided what they asked for.<br><br>On 5/6/24 at 1:08 PM, R66 was asked about their lunch meal and said It tastes like chicken. It was noted the ticket did not contain the menu items served to R66. R66 said the ticket never listed their food items and they were never provided with a menu. R66 said they would like a hamburger every once and awhile. They further verbalized their frustration about not receiving coffee.<br><br>On 5/6/24 at 1:12 PM R35 was asked about their lunch meal. They said they requested chicken tenders but they received the regular menu item, stating, I didn't ask for that.<br><br>On 5/8/24 at 8:55 AM, R66's breakfast meal was compared with their meal ticket, the ticket indicated R66 should have been served coffee with sweetener and creamer, however; no coffee was observed.<br><br>On 5/8/24 at 8:57 AM, R70's breakfast meal was compared against their meal ticket. The ticket indicated R70 preferred cold cereal, however; R70's meal contained oatmeal and no cold cereal.<br><br>On 5/8/24 at 9:00 AM, R41's breakfast meal was compared against their meal ticket. The ticket indicated they preferred cold cereal with milk only for the cereal, no to drink. R41's meal appeared to contain oatmeal and two cartons of milk.<br><br>On 5/8/24 at 9:02 AM, R68's meal was observed and they indicated they had not been served their oatmeal, oatmeal was listed on their ticket as having to be provided.<br><br>5/8/24 at 12:42, R35's lunch meal was compared to the meal ticket. The ticket indicated R35 was to be served a grilled cheese sandwich and tomato soup. The meal contained the sandwich, but no soup. R35 also complained about the fudge brownie served to them for dessert. R35 said they didn't like chocolate. A closer review of their meal ticket was conducted and the ticket read, NO fudge brownies.<br><br>On 5/8/24 at 1:06 PM an interview was conducted with the facility's Dietary Manager. They were asked about food preferences, meal tickets, and ensuring residents received the food/drink of their choosing. They manager explained the process of the tray line and acknowledged ongoing issues with ensuring tickets matched meals and resident's choices were honored.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of a facility provided policy titled, Food Preference and Portions dated 9/2021 was conducted and read, .7. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet orders, allergies & intolerances, and preferences . |

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| | 235396 | A. Building<br>B. Wing | 05/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Villa at Silverbell Estates | 1255 W Silverbell Rd<br>Orion, MI 48359 |

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) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>22960<br><br>Based on observation, interview, and record review, the facility failed to ensure food was prepared served, and stored in a sanitary manner for one resident (R32) of one resident reviewed for food storage. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include:<br><br>On 5/6/24 between 8:45 AM-9:30 AM, during an initial tour of the kitchen, the following items were observed:<br><br>Dietary Staff L was observed with a long beard, but was not wearing beard restraint. Dietary Manager K confirmed Staff L should have on a beard restraint.<br><br>According to the FDA Food Code section 2-402.11 Effectiveness, (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.<br><br>There were 3 ceiling vent covers observed with dust and peeling paint on the surface.<br><br>According to the 2017 FDA Food Code section 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition, (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials.<br><br>There was a large puddle of brown liquid on the table where the coffee machine was located.<br><br>According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.<br><br>The ice scoop holder was observed with black debris on the bottom interior surface. Dietary Staff L confirmed the soiled ice scoop holder, and stated it would be cleaned in the dish machine.<br><br>According to the FDA 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: . (E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food) .<br><br>The backsplash behind the drainboard on the soiled side of the dish machine observed with cracked, missing tiles and a black mold-like substance on the tiles. Dietary Manager K confirmed the soiled and broken tiles, and stated he would let maintenance know.<br><br>According to the 2017 FDA Food Code section 6-501.11 Repairing, Physical facilities shall be maintained in good repair.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In the dry storage room, there was spilled light brown powder at the bottom of a bin containing fruit punch beverage mix and also inside a box containing bags of marshmallows.<br><br>According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean.<br><br>The resident refrigerator located in the dining room was observed with an interior temperature of 49 degrees Fahrenheit. In addition, there were 2 opened cartons of milk with use by date of 4/23/24, an opened, undated bottle of thousand island dressing, an undated, uncovered bowl of diced fruit, 2 cartons of milk with a use by date of 5/3, and an undated bowl of wilted salad.<br><br>Review of the facility's policy Food Safety Requirements Guideline dated 11/28/17, .4. Proper labeling and dating of each item. 5. Leftover foods will be used within 3 days or discarded. 6. All refrigerators will be at 41 degrees F.<br><br>34208<br><br>R32<br><br>On 5/6/24 at 10:41 AM and 5/7/24 at 12:45 PM, R32's bedside table was observed to contain two peanut butter and jelly sandwiches in clear storage bags. The sandwiches were not observed to have a preparation date or a discard date.<br><br>On 5/8/24 at 10:41 AM, R32's bedside table was observed to have three peanut butter and jelly sandwiches in clear bags. They were not observed to have a preparation date or a discard date. It was further noted fruit flies were present in the room at that time.<br><br>On 5/6/24 at 1:06 PM, Certified Nurse Aide (CNA) 'B' was observed delivering meal trays to the unit. The trays containing the meals had bowls of cobbler for dessert. The bowls were not observed to be covered and the cobblers were open to air as the trays were delivered to the rooms on the unit.<br><br>On 5/8/24 at 11:24 AM, an observation of a resident refrigerator was conducted. The outside of the refrigerator had a sign that indicated all food in the fridge must be labeled with a resident's name and should be dated. The fridge was observed to contain a wrapped burrito with no resident name and a manufacturer's use by/freeze by date of 5/4/24. The fridge further contained a bowl of tomato bisque and a package of pepperoni slices that contained no resident name or dates.<br><br>Review of the facility's policy Food Safety Requirements Guideline dated 11/28/17, .4. Proper labeling and dating of each item. 5. Leftover foods will be used within 3 days or discarded. 6. All refrigerators will be at 41 degrees F. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271<br><br>Based on interview and record review, the facility failed to ensure pertinent resident information was documented in the medical record for one resident (R24) of one resident reviewed for Social Services/Guardianship resulting in the potential for clinical misrepresentation of the resident and errors in providing a continuum of care. Findings include:<br><br>On 5/6/24 at approximately 9:50 a.m., R24 was observed to be confused and unable to answer any questions.<br><br>On 5/6/24 the medical record for R24 was reviewed and revealed the following: R24 was initially admitted to the facility on [DATE] and had diagnoses that included: Adult failure to thrive, Dementia and Cerebral Infarction (stroke). A review of R24's MDS (minimum data set) with an ARD (assessment reference date) of 3/25/24 revealed R24 had a BIMS score (brief interview of mental status) of one indicating severely impaired cognition. Further review of the medical record revealed R24 did not have a legal representative to assist with informed decision making.<br><br>A facility document tilted Determination of Capacity with an effective date of 2/9/24 and signed by two Physicians was reviewed and revealed the following: The resident does not have the cognitive capacity to participate in his/her own medical and financial decisions .Diagnosis affecting the residents decision-making ability is as follows .Dementia.<br><br>Further review of the medical record did not reveal any recent notes on obtaining a legal representative to advocate on behalf of the resident and assist them with informed decision making.<br><br>On 5/08/24 at approximately 9:49 a.m., during a conversation with social service worker F (SS F), SS F was queried if they had assisted the resident and their niece regarding obtaining a decision maker for R24 since they had been deemed incapacitated. SS F reported that they have had conversations with multiple public guardianship agencies, had contacted R24's national embassy and had conversations with the Ombudsman's office pertaining to resources on getting R24 a legal guardian but had no results due to R24 not being a citizen. SS F was queried for documentation pertaining to their conversations with the multiple guardianship agencies, Ombudsman's office and embassy. SS F reviewed the record and indicated that they had no documentation pertaining to those conversations with the different agencies and where the guardianship process was currently at for R24. SS F reported they were going to improve on their documenting in the record with regards to the social service needs and processes for R24. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>34208<br><br>Based on observation, interview, and record review, the facility failed to appropriately implement enhanced barrier precautions (EBP, infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) and wear the required personal protective equipment (PPE) for resident's on EBP for four residents, (R#'s 64, 45, 49, and 33) of seven residents reviewed for transmission based precautions, resulting in the potential for the transmission of multidrug-resistant organisms. Findings include:<br><br>On 5/6/24 at 10:18 AM, R64 and R45 were observed in their beds. They were each observed with a urinary catheter. There was no signage on the door that indicated the residents were treated with enhanced barrier precautions (EBP), as defined by the Center For Disease Control, .Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .<br><br>On 5/6/24 at approximately 11:05 AM, an interview was conducted with R49. They indicated they had a urinary catheter, a colostomy, and wounds on their buttocks. R49's room was not observed with any signage indicating they were treated with enhanced barrier precautions.<br><br>On 5/6/24 at 12:39 PM, R33 was observed in their room with a feeding tube. R33's room was not observed with any signage indicating they were treated with enhanced barrier precautions.<br><br>48680<br><br>On 5/8/24 at 11:28AM, the Director of Nursing (DON) was interviewed about the infection control program at the facility. The DON was asked about enhanced barrier precautions and how the facility planned to incorporate the standards. The DON said for enhanced barriers they started the education with the staff and residents. They further went on to say they starting cohorting (rooming together) like residents and did room moves for people, but they could not put all of the precautions into effect until all the staff were educated. They further said it was just a recommendation from the Center for Disease Control.<br><br>A review of a facility provided document from the Center for Disease Control titled Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated June 2021 was reviewed and read, .2. enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. Aureus (type of infection) and MDRO's (multi-drug resistant organisms) . |