

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Beaconshire Nursing Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 21630 Hessel Detroit, MI 48219	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958</p> <p>This citation pertains to intake MI00146029.</p> <p>Based on interview, and record review, the facility failed to prevent misappropriation of resident medication for one resident (R101) of three reviewed for misappropriation, resulting in resident experiencing pain and the potential for misappropriation to continue.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed, R101 admitted to the facility on [DATE] with pertinent diagnosis which included quadriplegia and muscle wasting and atrophy.</p> <p>Review of a Minimum Data Set (MDS) assessment dated ,d+[DATE] revealed R101 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 14 out of 15 and had a scheduled pain medication regimen.</p> <p>Review of Physician orders revealed R101 had an order for, Oxycodone 30 mg (milligrams) give 1 tablet by mouth every 6 hours for pain with a start date of 3/28/24.</p> <p>Review of a Medication Administration Record (MAR) for July 2024 revealed Oxycodone 30 mg not given on 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/20, 7/28, 7/29, and 7/30/24.</p> <p>Review of a Packing Slip dated 7/18/24 revealed, Oxycodone 30 mg was delivered for R101 signed by Licensed Practical Nurse (LPN) F.</p> <p>Review of a Physician progress note with a date of 7/31/24 at 3:04 p.m. revealed, Reason for Visit: I am seeing and treating the patient (pt) today for pain, as (Unit Manager H) told me the pt needed his pain meds re-ordered again. Chief Complaint: My neck and back hurt . I also am checking on the pt, as the Staff called me yesterday (7/30/2024) to tell me they think some of the pt's Oxycodone meds were missing. I called the Pharmacy today and they said they delivered 30 Oxycodone pills on 7/18 and 30 pills on 7/20/2024. The concern is what happened to the 30 Oxycodone pills from 7/18 that were delivered and signed for . There should have been no need to send an additional 30 pills on 7/20, as the 7/18 pills would have lasted 7-8 days .</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 8/8/24 at 10:14 a.m., R101 reported informing the Director of Nursing (DON) and Physician about the missing pain medication. R101 reported the pharmacy sent a seven-day supply but they had to wait for another order after that. R101 reported experiencing increased pain and with mild withdrawal symptoms during the time the pain medication was missing.</p> <p>In an interview on 8/8/24 at 10:21a.m., the DON reported on 7/18/24 a 30 count of Oxycodone 30 mg was reported missing for R101. The DON then reported the nurse could not find the pain medication that was delivered for R101. The DON reported being made aware of the situation by the nurse and R101.</p> <p>In an interview on 8/8/24 at 1:29 p.m., Pharmacy Manager G reported the Oxycodone 30 mg was delivered on 7/18/24. Pharmacy Manager G then reported there is a signed delivery sheet from the driver and nurse.</p> <p>In an interview on 8/8/24 at 1:43p.m. Unit Manager H confirmed the pharmacy delivered medications multiple time on 7/18/24. Unit Manager H reported on 7/19/24 they noticed R101 did not have any Oxycodone and the pharmacy was called about the medication.</p> <p>In an interview on 8/8/24 at 2:06 p.m., Pharmacy Driver I confirmed delivering medications on 7/18/14 for R101 and a nurse signed for the medications.</p> <p>In an interview on 8/8/24 at 2:26 p.m. the Nursing Home Administrator (NHA) reported being made aware of the missing pain medication by the DON.</p> <p>In an interview on 8/8/24 at 3:41 p.m., the Director of Nursing (DON) reported the Oxycodone for R101 was confirmed as missing.</p> <p>Review of a Abuse, Neglect and Exploitation policy revised 7/23/34 documented, It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958</p> <p>This citation pertains to intake MI00146029.</p> <p>Based on interview and record review, the facility failed to report allegations of misappropriation for one (R101) of three residents reviewed for misappropriation.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed, R101 admitted to the facility on [DATE] with pertinent diagnosis which included quadriplegia and muscle wasting and atrophy.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R101 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 14 out of 15 and had a scheduled pain medication regimen.</p> <p>Review of Physician orders revealed R101 had an order, Oxycodone 30 mg (milligrams) give 1 tablet by mouth every 6 hours for pain with a start date of 3/28/24.</p> <p>Review of a Packing Slip dated 7/18/24 revealed, Oxycodone 30 mg was delivered for R101 signed by Licensed Practical Nurse (LPN) F.</p> <p>Review of a Physician progress note with a date of 7/31/24 at 3:04 p.m. revealed, Reason for Visit: I am seeing and treating the patient (pt) today for pain, as (Unit Manager H) told me the pt needed his pain meds re-ordered again. Chief Complaint: My neck and back hurt .</p> <p>I also am checking on the pt, as the Staff called me yesterday (7/30/2024) to tell me they think some of the pt's Oxycodone meds were missing. I called the Pharmacy today and they said they delivered 30 Oxycodone pills on 7/18 and 30 pills on 7/20/2024. The concern is what happened to the 30 Oxycodone pills from 7/18 that were delivered and signed for . There should have been no need to send an additional 30 pills on 7/20, as the 7/18 pills would have lasted 7-8 days .</p> <p>In an interview on 8/8/24 at 10:14 a.m., R101 reported informing the Director of Nursing (DON) and Physician about the missing pain medication.</p> <p>In an interview on 8/8/24 at 10:21a.m., the DON reported on 7/18/24 a 30 count of Oxycodone 30 mg was reported missing for R101. The DON then reported the nurse could not find the pain medication that was delivered for R101. DON acknowledged the incident was not reported to the state agency.</p> <p>In an interview on 8/8/24 at 1:43p.m. Unit Manager H confirmed the pharmacy delivered medications multiple time on 7/18/24. Unit Manager H reported on 7/19/24 they noticed R101 did not have any Oxycodone and the pharmacy was called about the medication.</p> <p>In an interview on 8/8/24 at 2:06 p.m., Pharmacy Driver I confirmed delivering medications on 7/18/24 for R101 and a nurse on 1 South signed for the medications.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 8/8/24 at 2:26 p.m. the Nursing Home Administrator (NHA) reported the missing narcotics was not reported to the state agency. NHA reported abuse including misappropriation should be reported when there is an allegation or suspicion. NHA reported abuse should be reported to the state agency immediately before the investigation begins.</p> <p>Review of a Abuse, Neglect and Exploitation policy revised 7/23/34 documented, It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other agencies within specific timeframes: a. Immediately but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958</p> <p>This Citation Pertains to Intake MI00146029.</p> <p>Based on observation, interview and record review the facility failed to follow the procedure for reconciling controlled substances (drugs that have high potential for abuse and misappropriation) for one (R102) resident from one of four medication carts reviewed for medication storage, resulting in the potential for drug diversion to go undetected.</p> <p>Findings include:</p> <p>In an observation and interview on 8/8/24 at 11:23 a.m. R102 had seven APAP Codeine 300-30mg (controlled substance, pain medication) tablets in the medication cart. The medication was counted on a Authorization For Controlled Substance Dispensing document. R101 did not have a proof of use record that included the dates, times or signature of medication removal. Licensed Practical Nurse (LPN) B reported they are counting the medication when they remove it but not signing it out.</p> <p>Review of an Admission Record revealed, R102 admitted to the facility on [DATE] with pertinent diagnosis which included dementia and fracture of skull and facial bones.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R102 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 1 out of 15.</p> <p>Review of Physician orders revealed R102 had an order, Acetaminophen-Codeine Tablet 300-30mg give 1 tablet by mouth every 6 hours as needed for pain with a start date of 10/30/23.</p> <p>In an interview on 8/8/24 at 3:14 p.m. LPN A reported nurses should sign out narcotics on a form and include date, time, signature and count.</p> <p>In an interview on 8/8/24 at 3:19 p.m. LPN B reported narcotics should be signed out on the narcotic sheet with date, time, count, and signature.</p> <p>In an interview on 8/8/24 at 3:41 p.m., the Director of Nursing (DON) reported the nurses should sign out narcotics when they are removed from the medication cart.</p> <p>Review of a Pharmacy Services policy with a revised date of 8/8/24 documented, It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice . The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. The facility will employ or obtain the services of a licensed pharmacist (in accordance with state requirements) who:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> o Provides consultation on all aspects of the provision of pharmacy services in the facility; o Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and o Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled .