STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomeroy Living Rochester Skilled Rehabilitation	3500 West South Blvd Rochester Hills, MI 48309

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake(s): MI00146420, MI00146542, MI00146558, MI00145342, & MI00147417. Based on interviews and record reviews the facility failed to ensure medications and treatments were administered/applied as prescribed by the physician, failed to ensure the timely administration of medications and failed to treat a change of condition timely for three (R's 401, 402, & 403) of five residents reviewed for medications/treatments. Findings include: R402 A review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to address R402's change of condition timely which resulted the R402 leaving the facility Against Medical Advice (AMA). A review of the medical record revealed R402 was admitted to the facility on [DATE] and discharged against medical advice on 7/22/24. R402 was admitted with diagnoses that included: aftercare following surgery, absence of left leg below the knee A review of the medical record revealed the following progress notes: A Nursing note on 7/22/24 at 12:26 PM, documented in part . Res (resident) had one episode of emesis noted . Writer contacted NP (nurse practitioner) and NP gave verbal order for STAT (immediate) abdominal x-ray to be completed . A Nursing note on 7/22/24 at 4:30 PM, documented in part . Writer had multiple encounters with res and partner at bedside. Partner requested that the ABD (abdominal) plate x-ray that was ordered to be stopped. NP not in agreeance . res still vomiting. Writer was given order to give a 1 time dose of Zofran. Order was given. When giving medication partner attempted to give medication and res would not open mouth, res stated 'fuck you', partner then says yeah you made <sic> and then says 'yeah the nurse can hear you'. Partner then proceeded to say we want to leave and gave writer paper with home care information on it. Writer then explained that this was already discussed last week and that the MD (medical doctor) was not okay with res leaving at this time, for safety reasons. Writer then went to UM (unit manager) and explained the situation. UM came out of room and stated res and stated <sic> that it will be an AMA. NP notified of res going AMA. Paperwork signed . (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above notes were documented by Licensed Practical Nurse (LPN) B. The UM mentioned in the above note was no longer employed at the facility at the time of the survey. On 10/15/24 at 1:27 PM, a voicemail was left on LPN B's cell phone. LPN B did not reply or return this surveyor's call. A review of the medical record revealed the nurse failed to implement the Zofran order as documented above. Further review revealed no documentation of the Zofran to have been administered to the resident. A STAT x-ray was ordered at 12:26 PM, and had not been completed by 4:30 PM, when the resident decided to sign out AMA. On 10/15/24 at 2:55 PM, the Director of Nursing (DON) was interviewed and asked about the incident that involved R402 leaving the facility AMA. The DON stated they remembered the resident and incident and remembered being informed by LPN B that the resident was sick and vomiting. The DON stated LPN B informed them that they notified the physician and received an order for Zofran and an abdominal x-ray. The DON stated the nurse informed them of R402 wanting to the leave the facility. The DON was asked why the Zofran order was never transcribed in the resident's chart and administered. The DON stated they would look into it and follow back up. On 10/16/24 at 8:26 AM, a follow up interview was conducted with the DON. The DON stated they were not able to find a Zofran order implemented for R402. The DON stated the facility has a policy for Zofran to be a standing order for the residents. The DON was then asked why the standing order for Zofran had not been transcribed in the residents record for administration and the DON acknowledged the concern. No further explanation or documentation was provided by the end of the survey. R403 Review of a complaint submitted to the SA documented allegations of the facility night shift nursing staff failing to consistently apply their skin treatment and failing to administer their medication timely as ordered by the physician. A review of the medical record revealed R403 was admitted to the facility on [DATE] with medical diagnoses that included: chronic respiratory failure, chronic obstructive pulmonary disease (copd), and anxiety disorder. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 that indicates intact cognition. Review of the medication administration audits for the month of August and October 2024 revealed the following: August- on 8/24/24 Magnesium gluconate 12.5 mg (milligram) scheduled for 9:00 PM was administered at 2:56 AM on 8/25/24. Triad paste to the buttocks and upper inner thighs was ordered to be applied twice a day. The medication was not applied on the night shift for the dates of 8/14, 8/19, 8/21, 8/22, 8/23 and 8/31/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October- on 10/5/24 Aripiprazole 5 mg, Carvedilol 6.25 mg, Cholecalciferol 50 mcg, Claritin 10 mg, Cymbalta 60 mg, Docusate sodium 100 mg, Dulero aerosol inhaler, Flonase nasal spray, Multivitamin, Lasix 40 mg, Lisinopril 20 mg, Miralax 17 gm (gram), Norvasc 5 mg, Pepcid 10 mg, Prozac 20 mg and Spiriva inhalation solution all scheduled for 9AM (except Aripiprazole & Flonase scheduled for 10 AM), were all administered at 11:45 AM. A review of the facility policy titled Medication Pass Guidelines updated 8/2011, documented in part . Purpose To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing the administration of drugs in an accurate, safe, timely, and sanitary manner . Administer medication within 60 minutes before or after the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility . On 10/16/24 at 9:43 AM- the DON was interviewed and asked about the expectations of the nursing staff to administer medications timely to the residents. The DON confirmed that medications should be given within the hour before and after the schedule time. The DON stated per their knowledge they have not received any feedback from the floor nursing staff regarding not being able to administer their medications timely. The DON was asked about the expectations of skin treatment being applied during the nightshift and the DON acknowledged the skin treatment should be applied as ordered by the physician. No further explanation or documentation was provided by the end of the survey. 34275 R401 A complaint was filed with the State Agency (SA) that alleged R401 was not getting their physician ordered pain patch weekly. The complainant reported that on 5/31/24 they went to visit R401, and they had a pain patch on that was dated 5/11/24. A review of R401's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included, in part, the following: rheumatoid arthritis, depressive disorder and obstructive sleep apnea. The resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intake cognition). Continued review of R401's clinical record noted an order dated 5/10/24 that read: .buprenorphine 10 mcg (micrograms)/hour weekly transdermal patch .apply patch by transdermal route (administered on skin) every week for 1 month .for pain . A second order read: .5/13/24 .Order: Buprenorphine 10 mcg .apply 1 patch .by transdermal route every week .on Friday at 10:00 AM . A review of R401's Medication Administration Record (MAR) for the month of May 2024 noted the resident received the buprenorphine patch on 5/11/24 and/or 5/12/24. There was no documentation that indicated the resident received any further patch for the month of May 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at approximately 9:36 AM, an interview and record review were conducted with the Director of Nursing (DON). The DON was asked as to why R401 did not receive the buprenorphine pain patch as ordered in May 2024. The DON reported that they believed the order was to apply the patch monthly. The DON was asked to provide documentation and/or orders that indicated R401 was to receive the pain patch monthly. No documentation was provided by the end of the survey.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake(s) #'s MI00145342 and MI00146542. Based on interview and record review the facility failed to provide oxygen (O2) services per physician order for two (R401 and R403) out of five residents reviewed for respiratory services resulting in R401's O2 saturation levels dropping to an extremely low level requiring immediate hospitalization . Findings include: R401 A complaint was filed with the State Agency (SA) that alleged on 7/2/24, R401 was sent to an outside medical appointment with their pulmonologist with an empty Oxygen (O2) tank. The resident's 02 saturation level dropped to 80% (a low level requiring immediate medical attention-normal readings are between 90-100%). The physician's office attempted to use an oxygen concentrator to improve the resident's oxygen level however they were unable to do so. The physician's office then sent R401 via EMS (emergency medical services) to the hospital. A review of R401's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included, in part, the following: rheumatoid arthritis, depressive disorder and obstructive sleep apnea. The resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intake cognition). An order with a start date of 12/26/23 documented R401 was to receive Oxygen via a nasal cannula at the rate of 2 L (liters) continuously. A progress note dated 7/2/24 at 11:12 PM noted, resident went to a doctor's appointment in the morning, did not return during evening shift, a call was received by one of the nurses in the unit, was told that resident was sent to hospital from Doc's office. (Name redacted) Hospital records with an admitted [DATE] noted, .Name: R401 .Chief complaint: patient presents with hypoxia (an absences of enough oxygen in the tissues to sustain bodily functions) .had been sent by facility to med eval with a depleted O2 tank. Pt was hypoxic and transferred to hospital .admitted . Assessment and Plan: Hypoxia due to mechanical supply issue .02 dependence .Xray-chest .concerning for pneumonia .Differential Diagnosis: includes but not limited to hypoxia secondary to lack of oxygen .ED (emergency Department) .presents with complaints of shortness of breath. He was at pulmonology appointment and he was sent there without oxygen. His oxygen was low on arrival. EMS (emergency medical services) was called he could not get his sats up even with a non-breather. He was transported to our facility .EMS reports c/c (concerns) of hypoxia and SOB (shortness of breath) that occurred today. EMS states .center did not place pt on baseline 2 L 02 and his 02 levels desated to 70-80%. Pt returned to appropriate 02 levels when EMS arrived and placed on 12 L NRB (non-rebreather - mask that provides a high concentrate of oxygen . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at approximately 9:36 AM, an interview was conducted with the Director of Nursing (DON). The DON was queried as to R401 being sent to their pulmonologist with an empty tank of oxygen. The DON reported that they were aware of the incident and noted that the facility's Assistant Director of Nursing (ADON) A tried to deliver a full tank of 02 to the physician's office but the resident had been taken to the hospital via EMS. The DON reported that the nurse should have ensured that the resident's tank was full prior to sending them out for their appointment. On 10/16/24 at approximately 9:47 AM, an interview was conducted with ADON A. When queried as to incident involving R401, ADON 'A reported that they were made aware that the resident was sent with an empty 02 tank but did not recall bringing one to the physician's office. ADON A reported that Nurse F was the staff person working with R401 and they should have ensured the resident was sent with full tank of 02. On 10/16/24 at approximately 10:49 AM, an interview was conducted with Nurse F. When asked about R401 being sent out without a full tank of 02, Nurse F reported that they believed the tank was full and noted that perhaps it leaked during transfer. Nurse F reported that they received in-service education on ensuring residents who required 02 were provided a necessary amount prior to leaving the facility. Review of the facility policy titled, Oxygen Administration (release date: 2011) documented, in part, the following: Purpose: A resident will receive oxygen per physician's orders and facility protocol .Oxygen source: cylinder, liquid tank, or concentrator . 41415 R403 Review of a complaint submitted to the State Agency (SA) documented concerns of R403 having difficulty breathing due to the staff failure to follow the supplemental oxygen liter order as prescribed. A review of the medical record revealed R403 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, chronic obstructive pulmonary disease (copd) and obstructive sleep apnea. At the time of survey R403 was admitted to the hospital. A review of the physician orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented the following orders: Oxygen Device: nasal cannula Rate: 4 L (liters)/min (minute) Continuous. Times of Administration 7 AM to 7 PM and 7 PM to 7 AM- 24 hours continuously. Cpap (continuous positive airway pressure) with 02 (supplemental oxygen) 3 liters on at q (every) hs (hour of sleep). Start date: 7/13/24. This revealed the facility had two oxygen orders implemented with different oxygen liters to be administered at the same time. Further review of the MARs and TARs revealed the facility nurses signing off for both the 3 and 4 liters of oxygen being administered at the same time duration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed no documentation of the identification of the conflicted orders and no documentation of the clarification of how many liters should have been administered to the resident during sleeping hours. On 10/15/24 at 3:35 PM, the Director of Nursing (DON) was interviewed and asked about the supplemental oxygen continuous order of 4 L and asked about the CPAP orders of 3 L to be administered during the same time period and asked which order the nurses were supposed to follow and implement. The DON stated they would look into it and follow back up. On 10/16/24 at 8:28 AM, a follow up interview was conducted with the DON and with the ADON (assistant director of nursing) in attendance. The DON and ADON were asked about the follow up of the supplemental oxygen administration concerns. The DON stated they identified that the CPAP liters was recommended by the respiratory therapist, however the continuous oxygen order was ordered by the primary physician. The DON and ADON was asked why no one clarified the orders with the physician and/or why the respiratory therapist was not instructed to coordinate the oxygen administration care with the primary physician. The DON and ADON acknowledged the concern and stated moving forward they would ensure the coordination of care and ensure all conflicting orders were clarified. No further explanation or documentation was provided by the end of the survey.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake(s): MI00145837. Based on observation, interview and record reviews the facility failed to ensure meals were served at a desirable temperature for three (R's 404, 405 & 406) of five residents reviewed for meals, including residents via the resident council meeting resulting in meal dissatisfaction. Findings include: Review of multiple complaints submitted to the State Agency (SA) documented concerns regarding the palatability of the facility's food. On 10/15/24 at 12:41 PM, an interview was conducted with R405. R405 verbalized concerns regarding the facility's food. R405 stated in part . breakfast was always ice cold and stated their kids brought them food to the facility every day to eat because the facility's food was inedible. On 10/16/24 at 7:56 AM, Dietary Aide (DA) D was observed delivering the food tray cart for unit A. At 8:00 AM, the aide was observed obtaining the trays to provide the residents on unit A with their breakfast tray. Observed on top of the cart were two resident trays, as well as multiple resident trays observed inside of the cart. At 8:04 AM, one of the trays that was observed on the top of the cart was obtained for a test tray review. Identified on the tray was a coffee with notable steam coming from the top ,orange juice that felt cold to touch, oatmeal, brown sugar, salt/pepper, creamer, 2% reduced fat milk, pancakes, eggs, and a round sausage. A taste of the oatmeal and eggs were noted to be warm. A bite into the pancake and sausage was noted to be cold. A second bite from the middle of both the pancake and sausage was confirmed to be ice cold. 47283 R406 R406 was a long-term resident, originally admitted to the facility on [DATE]. R406's admitting diagnoses included lung cancer, respiratory failure, heart failure, anxiety disorder, and chronic obstructive pulmonary disease (COPD). Based on the current Minimum Data Set (MDS) assessment, R406 had a Brief Interview for Mental Status (BIMS) score 15/15, indicative of intact cognition. An initial observation was completed on 10/15/24 at approximately 10:30 AM. During an interview R406 reported that they had a concern about cold food. R406 added that they preferred to eat in their room and the food was cold on most days. When queried further if that any pattern such as any particular meal or days, R406 reported that it was lunch and dinner that was served cold. R406 added that cold breakfast was also an issue on some days. R406 reported that meat gets overcooked and tough. During the interview R406's spouse was present in the room. They reported that it was an ongoing concern. Later that day at approximately, 1:40 PM, R406 was observed sitting up in their wheelchair and eating lunch. When queried about their lunch, R406 reported that it was cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24, at approximately 9:00 AM, R406 was observed in their bed eating breakfast. R406 was queried about their breakfast. Reported that they liked what they had, still not hot, warmer than usual. Review of facility's resident council minutes from 10/15/24 revealed that residents who attended the meeting had concerns about cold food. It read, Breakfast is always cold and dinner is sometimes cold. On 10/16/24 at approximately 8:20 AM a dietary staff member delivered the breakfast cart to [NAME] - C hall. At approximately 5 minutes later Registered Dietician (RD) E was asked to pull a tray from cart to check the serving temperatures. Temperatures were checked by the RD. Pancakes were at 98 degrees and scrambled eggs were at 115 degrees. An interview with the RD E was completed on 10/16/24 at approximately 8:20 AM. They were queried about the serving process. RD E reported that most residents ate breakfast in their rooms. Trays were prepared in the kitchen and they were sent on the carts to each unit. They added for lunch and dinner the food was served from the satellite kitchen/steam tables from the dining room. When queried further about the meal service for residents who preferred to eat in their rooms, they added that staff were serving from the steam table, individually. The trays were assembled by the dietary staff member at the steam table and staff members delivered trays individually to every room for residents who were not in the dining room. When queried how did they monitor the temperature of the trays they were prepared, how did they ensure food temperature was maintained on the assembled trays, and the trays were delivered timely to ensure appetizing temperature and palatability. RD E reported that staff were supposed to serve the assembled trays right away. They added that if they had staffing challenges they had used a cart to deliver lunch and dinner to deliver room trays and did not provide any further explanation. They were notified of the concern with food temperature. On 10/16/24 at approximately 12:20 PM, the Administrator was notified of the concerns with the cold food from multiple residents. They were notified of the concerns with the serving process for the residents who preferred to eat in their rooms and they reported that they understood the concern and they would follow up. A facility policy on food palatability was requested via e-mail. The survey team did not receive the appropriate policy prior to survey exit. 34275 R404 On 10/15/24 at approximately 11:45 AM, R404 was observed in their bedroom sitting on their bed. The resident was alert and able to answer questions and asked about life at the facility. R404 noted that their biggest concern at the facility was the food. They reported that the food is often cold and on a number of occasions they do not get what they ordered, specifically, coffee. Review of a Resident Assistance Form (Grievance) dated 7/28/24 documented, in part: Name (R404) .What is your concern: Not getting coffee with lunch or dinner .When did the problem or incident occur .over the past 2 months but past weekend was bad . (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R401's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease, depressive disorder and type II diabetes. A review of the residents MDS noted the resident's BIMS score was 14/15 (cognitively intact cognition).