STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235499	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Nursing Center	600 Denmark St Baldwin, MI 49304

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00143988. Based on interview and record review, the facility failed to maintain complete, timely, and accurate medical records for 1 of 4 residents (R4), resulting in the potential for providers not having an accurate, complete, and timely picture of the resident's stay at the facility. Findings include: A review of R4's Admission Record, dated 5/22/24, revealed R2 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R4's Admission Record revealed multiple diagnoses that included Dementia. A review of R4's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/13/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R4 had short-term and long-term memory problems with inattention and disorganized thinking. R4's BIMS assessment also revealed R4 had severely impaired cognitive decision making skills. A review of the facility's investigation report, dated 4/12/24, revealed on 4/4/24 at 6:45 PM, R4 became agitated and grabbed R3's arm which resulted in scratches. After she (R4) was redirected away from R3 she walked over and slapped R2 in the back of head before she could be redirected. Resident (R4) was successfully redirected to another area of the building. Resident (R4) will be accompanied by staff member until no continued observation of heightened agitation. A review of R4's progress notes, dated 4/1/24 to 5/21/24, revealed the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Grand Oaks Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Denmark St Baldwin, MI 49304	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Interdisciplinary Documentation, dated 4/5/24, revealed, Collaboration with provider regarding constipation and observed increased agitation with bowel movements. Review of [name of R4] BM (bowel movements) over the last 30 days initially show irregularity with increased regularity over the last 14 day look back period. Interviews with staff indicate increased agitation with direction and assistance using toilet. [Name of R4] observed at times guarding her stomach when having bowel movements. [Name of R4] at times requires multiple approaches for medication administration which includes her Senna (a laxative). [Name of R4] does take Miralax (another laxative) daily. Review of medications and order to change senna capsule to a liquid to promote increased compliance. 4 oz (ounces) of prune juice to be added to each meal tray to help promote regularity. Increased fluid intake promoted with use of sensory engagement staff. Staff to encourage 240 ml (milliliters) each shift in addition to meal trays. Frequent routine toileting while participating in the sensory engagement room. Further review of implemented changes to be assessed with provider at next visit. Ativan (a sedative) tablet changed to Ativan gel to encourage compliance as [name of R4] often times will spit the pills out and other times requires multiple approaches by different staff members to be accepting of her medications. [Name of R4] spent a significant amount of time in the sensory engagement room and is observed to be more easily re-directed in areas of decreased stimulation. - Interdisciplinary Documentation, dated 4/12/24, revealed, BIM:99 (an incomplete resident interview assessment of cognitive status), observed by [Name of Social Worker (SW) B] on 4/10/2024 regarding unusual occurrence that took place on 4/4/2024. [Name of R4] displays relaxed body and facial expression, she is engaging in the sitting area folding laundry and arranging flowers in a basket. No psychosocial distress observed. A further review of R4's medical record, dated 4/1/24 to 5/23/24, failed to reveal any mention of the incident on 4/4/24 in R4's medical record, except for the Interdisciplinary Documentation note by SW B on 4/12/24 that she observed R4 regarding unusual occurrence that took place on 4/4/2024 and No psychosocial distress observed. However, the Interdisciplinary Documentation note by SW B did not mention what the unusual occurrence was (e.g., fall, resident-to-resident altercation- all events that the facility documents as unusual occurrences). During an interview on 5/22/24 at 12:15 PM, Social Worker (SW) B stated that if an incident occurs (e.g., a resident-to-resident altercation) then it should be documented in a progress note in the resident's record that it affects. During an interview on 5/22/24 at 4:00 PM, the Director of Nursing (DON) was informed that the surveyor could not locate a note regarding the incident (unusual occurrence) on 4/4/24. She stated she would look into it and see if she could locate one. The DON stated sometimes her Interdisciplinary Documentation note for a supervisory investigation of an unusual occurrence/collaboration with the provider is the note that specifies the incident. She stated if she cannot find a note, then she will do a late entry progress note. The DON stated her expectation is that the nurse should have written a progress note about the incident when it occurred on 4/4/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview on 5/22/24 at 4:05 PM, the DON stated her Interdisciplinary Documentation note dated 4/5/24 was regarding the incident on 4/4/24. She stated even though the note does not specify that it was addressing the resident-to-resident incident, it was a collaboration with the physician that included the incident. The DON stated the collaboration with the provider addressed R4's increased agitation with bowel movements and constipation. She stated they found this out when they did their investigation into the incident on 4/4/24. The DON further stated that she knows her own documentation had been lacking in detail, but she had been working on it. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice . Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care . Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings . (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 5/28/24). Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 5/28/24).