STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235502	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ch Rehab & Nurs Cnt - Commons Dearborn	16391 Rotunda Dr Dearborn, MI 48120

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review the facility failed to provide a bedpan timely for one incontinent resident (R11) of one resident reviewed for dignity, resulting in verbalizing feelings of embarrassment and frustration. Findings include: On 3/17/2025 at 10:47 a.m. R11 reported having a bowel movement in bed after turning on the call light for assistance that took over thirty minutes for a staff to answer the call light. During an interview R11 stated, I felt nasty because I did something nasty on myself. I felt angry, frustrated, and embarrassed. I wouldn't say this if I didn't mean it. I was so upset because I don't have bowel movements on myself. On 3/17/2025 at 10:55 a.m. assigned Certified Nursing Assistance (CNA) K was interviewed regarding resident's care. CNA K was asked if R11 was upset about having a bowel movement in bed because no one provided the resident with a bedpan. CNA K stated, Yes, the resident call light was on along with others at the same time. By the time I got to her she had pooped on herself, and she was upset. CNA K said R11 call light was on for about thirty minutes before it was answered and before the resident was changed. According to the electronic medical record, R11 was admitted to the facility on [DATE] with diagnoses of anxiety, hemiplegia and hemiparesis following a cerebrovascular disease (stroke) affecting the left dominant side, contracture of right hand and left knee, overactive bladder, and a history of constipation. R11's quarterly Minimum Data Set (MDS) with a reference date of 1/11/2025, indicated R11 had intact cognition with a BIMS (brief interview of mental status) score of 15/15 and incontinent of bowel and bladder. Review of the 8/11/2020 Activity of Daily Living (ADLs) care plan documented, (R11) is at risk for self-care deficit in ADLs functional Status/Rehabilitation Potential. Interventions: Bed mobility and transfers extensive assistance times two person. On 3/19/2025 at 1:50 p.m. the Director of Nursing (DON) said during an interview regarding R11's incontinent episode that the CNA's should have assisted the resident within fifteen or twenty minutes from the time the call light was turned on. The DON understood why the resident was upset and embarrassed especially if the resident normally uses the bedpan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's 12/2024 Dignity and Privacy policy: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 2. 'Treated with dignity' mean the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 Based on interview and record review, the facility failed to notify in a timely manner the Resident Representative (RR) for one resident (R24) of a change in condition requiring treatment, resulting in the RR not having the opportunity to participate in medical decisions regarding R24's health. Findings include: A review of the clinical record for R24 documented an initial admitted [DATE]. R24's diagnoses included dementia, pressure ulcer of sacral region-stage 4, congestive heart failure, and cerebral infarction. R24's spouse was listed as the responsible party and emergency contact. R24's son was listed as the RR. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. Additional review of R24's clinical record documented in part the following: 1. Wound care progress note dated 3/11/25: (R24) present with an acute skin tear of the right midline buttock. The wound is for initial evaluation. The wound was classified as a skin tear, length 0.91 centimeter (cm) and width 3.18 cm. Cleanse the wound with cleanser or saline solution and pat dry with gauze. Apply triad (a paste wound dressing) two times a day. 2. Nursing progress note dated 3/11/25: Patient received in bed, alert and verbal. Vital signs stable, ordered medications received and tolerated well. Foley in place and patent. Wound care performed rounds and completed patients wound treatment this shift. Will continue to monitor and maintain safety. Frequent visual checks for safety. 3. Nursing progress note dated 3/17/25: Husband in facility, provided update on wound progression and plan of care was discussed. Husband expressed understanding of information provided. Denied having any questions. During an interview and record review beginning on 3/19/25 at 12:06 PM, Unit Manager (UM) G said R24 had a skin tear and treatment was recommended. The family should be notified immediately and made aware of any changes when something happens with a resident. UM G said R24's clinical record should contain documentation that the family was contacted and referenced a progress noted dated 3/17/25 as evidence of family notification. During an interview on 3/19/25 at 12:16 PM, wound care nurse H said she rounds with the wound care team. Nurse H indicated that R24 did not have treatments in place for the skin tear prior to 3/11/25. Nurse H said the facility has a weekly wound and nutrition meeting and that would be when the family is notified. Nurse H acknowledged that waiting for the weekly wound meeting to occur may result in a delay in RR notification. During an interview on 3/19/25 at 1:52 PM, the Director of Nursing (DON) said the nurse should have tried to contact R24's spouse when the wound was discovered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Change of Condition Policy, undated but provided during the survey, documented in part the following: The nurse shall promptly notify the resident, his or her provider, and representative of changes in the resident's condition and/or status; and properly assess the resident for further care needs. On 3/19/25 at 4:30 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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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** 34901 Based on interview and record review, the facility failed to obtain a medication for a rare cardiac condition in a timely manner for one resident (R143). Findings include: A review of the clinical record for R143 documented an admission into the facility on [DATE] with diagnoses that included sepsis due to pseudomonas (a life-threatening infection caused by bacteria), cognitive communication deficit, and organ-limited amyloidosis (abnormal buildup of insoluble, elongated proteins primarily within a single organ) congestive heart failure. The hospital discharge summary dated 3/10/25 documented that R143 was to continue taking 61 mg of tafamidis (tafamidis [Vyndamax] is an oral medication used to treat a rare and progressive heart disease) by mouth daily. Additional review of R143's clinical record documented in part the following: Progress note of 3/13/25 at 2:29 PM: Received resident in bed awake, alert with confusion present. Resident received shift medications whole tolerated well no adverse reactions observed during shift .Writer paged MD in regards to medication Vyndamax 61 mg not delivered and unavailable in the cubex (a system to secure and provide controlled substances and other medications) to pull. Per (staff at pharmacy) the medication is very expensive and not covered by insurance. Writer contacted MD to see if an alternative can be used, writer awaiting a call back . During an interview and record review on 3/18/25 at 2:32 PM, Unit Manager (UM) G acknowledged that tafamidis was a cardiac related medication. After reviewing R143's clinical record, UM G could not provide documentation to support that any follow up had occurred regarding R143's cardiac medication since 3/13/25. UM G said they would have to page the physician because there was nothing noted in the clinical record. A review of R143's March 2025 Medication Administration Record documented that tafamidis had not been administered because the drug was not available since R143's admission into the facility. During an interview on 3/18/25 at 3:21 PM, the Lead Pharmacist (LP) I at the facility's contracted pharmacy was interviewed. LP I said Vyndamax was a specialty medication, and the facility sent the order for Vyndamax on 3/1/25. LP I said we documented that we could not supply the medication and provided a number for the facility to call for more information. A progress note of 3/18/25 at 4:20 PM documented in part the following: MD rounding with resident and was informed that Vyndamax had not been given (due to) its unavailability from the pharmacy. The physician was asked if there was an alternate med for use as the pharmacy said the medication is a specialty medication and they are unable to supply it. Physician is aware that medication is a special use med and does not want to order an alternate med. MD stated to contact the resident's family and ask them to bring the medication from home and start the medication then. Resident is stable and shows no change in condition. Resident's son was notified and informed of the unavailability of Vyndamax and agreed to bring the medication in this evening. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 1:58 PM, the Director of Nursing (DON) said when nursing discovered that tafamidis was not available they should have called the doctor immediately, did a cardiac follow up, and in this case, reached out to the family sooner especially since this was such a rare medication. On 3/19/25 at 4:30 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34901 Based on observation, interview, and record review, the facility failed to: 1. Properly clean and sanitize a thermometer stem prior to insertion into prepared food; 2. Ensure items stored in resident refrigerators were properly labeled with resident's name and expiration date; 3. Ensure pans were properly cleaned and allowed to air dry before stacking. These deficient practices had the potential to affect all the residents who consumed food from the kitchen, resulting in the increased likelihood for food borne illness. Findings include: On 3/17/25 at 11:18 AM, Dietary Aide (DA) F was observed in the facility's sub-kitchen taking the temperature of the following prepared foods in this order: turkey burger, mechanical soft turkey burger, pureed turkey burger, pureed sweet potatoes, gravy, pureed cauliflower soup, regular cauliflower soup, and sweet potato fries. DA F used a paper towel to wipe off the thermometer stem prior to inserting it into each food item. When queried about using a paper towel on the thermometer stem between taking food temperatures, DA F stated, I was told to not use alcohol wipes. On 3/19/25 at 10:46 AM, the resident refrigerator/freezer in the Unit A pantry was observed with Licensed Practical Nurse (LPN) C. A sign on the refrigerator door documented, No employee food or drink to be placed in this refrigerator! Resident's items must have date, their name and the room number. Thank You! A document titled, Refrigeration Temperature Record, dated March 2025, recorded refrigerator temperatures but not freezer temperatures. There was no thermometer in the freezer. A 12-ounce box of frozen lasagna and 7-ounce box of chicken pot pie were stored in the freezer and neither item was labeled with a resident name or dated. On 3/19/25 at 11:11 AM, the resident refrigerator/freezer on the Appoline unit was observed with LPN E. The Refrigeration Temperature Record, dated March 2025, only recorded the temperatures of the refrigerator. A thermometer was not available in the freezer. The following items, observed in the freezer, were opened, not labeled with a resident name, or dated: 1 gallon container of vanilla ice cream and 1.5-quart container of caramel delight ice cream. The following items were in the freezer unopened, not labeled with a resident name, or dated: sausage-egg-cheese croissant sandwich, 18.5-ounce bottle of unsweetened tea, and 10-ounce bottle of a hydration beverage. The refrigerator contained an unlabeled and undated plastic bag containing half-eaten pita bread and what appeared to be small blocks of soft cheese. On 3/19/25 at 11:30 AM, in a clean pot/pan storage area in the main kitchen, the surfaces of three sheet pans nestled together were observed to have droplets of water. One of the three sheet pans was not adequately cleaned and contained sticky substances. Director of Dining (DD) B stated the soiled sheet pan needs to be soaked and scrubbed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/19/25 at 11:50 AM, DD B said alcohol wipes should have been used to clean and sanitize the thermometer stem prior to inserting it into each food item. DD B said the wet sheet pans should have been allowed to air dry before stacking. Regarding the resident refrigerators, DD B said maintaining the resident refrigerators was everyone's responsibility, but at the end of the day, it was dietary's responsibility. Resident food stored in the resident refrigerators should have been labeled. Food not properly labeled should have been tossed. Dietary provides stickers for the labeling and dating. The thermometers should be in the refrigerators and freezers and the temperatures of both areas should be monitored. On 3/19/25 at 2:10 PM, the Nursing Home Administrator (NHA) stated, We expect in-house policies and procedures to be followed. A review of the facility policy titled, Food for Residents Brought in from the Outside, dated April 2024 documented in part the following: -Food/beverage brought in by family/friends for resident should be consumed within 3 days. If not consumed it should be discarded by the Midnight Shift. -The resident's nurse/CNA (Certified Nurse Aide) is responsible for checking the expiration date of all food from the unit refrigerator prior to serving to the resident. The 2013 FDA Food Code was reviewed and revealed the following: Section 4-602.11. Equipment Food-Contact Surfaces and Utensils: Equipment food-contact surfaces and utensils shall be cleaned (5) at any time during the operation when contamination may have occurred. Section 4-903.11. Storing Equipment, Utensils, Linens, and Single-Service and Single-Use Articles: (B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. On 3/19/25 at 4:30 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked.