

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Lakeview Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  408 N Fifth Ave Tawas City, MI 48763	

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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471</b></p> <p>Based on observation, interview and record review, the facility failed to implement timely interventions to prevent the development of a Stage 3 pressure ulcer for one resident (Resident #18) and an unstageable pressure ulcer for another resident (Resident #30), follow interventions, ensure that physician's treatment orders were followed and documented and prevent the worsening of the Stage 3 pressure ulcer for Resident #18 of three residents reviewed for pressure ulcers, resulting in Resident #18's development and worsening of a Stage 3 pressure ulcer and Resident #30's development of a left heel unstageable pressure ulcer with the likelihood of pain and infection.</p> <p>Findings include:</p> <p>Resident #18:</p> <p>On 4/02/2024, at 2:30 PM, a record review of Resident #18's electronic medical record revealed a readmission on 07/27/2023 after a short hospital stay with diagnoses that included Diabetes, weakness and Dementia. Resident #18 required extensive assistance with Activities of Daily Living (ADL) and had severely impaired cognition.</p> <p>According to the admission Minimum Data set Assessment (MDS) dated [DATE] . Section M . M0150. Risk of Pressure Ulcers. Is this resident at risk of developing pressure ulcers? The box 1. Yes. Was check marked.</p> <p>M0210. Unhealed Pressure Ulcer (s) Does this resident have one or more unhealed pressure ulcer (s) at Stage 1 or higher? The box 0. No was check marked.</p> <p>A review of the Skin &amp; Wound Evaluation . Date: 3/26/2024 . Type: . Pressure . Stage: Stage 3: Full-thickness skin loss . Location Right Lateral Foot . In-House Acquired . Exact Date 11/3/2023 . Wound Measures 1.58 x 0.78 cm .</p> <p>A review of the care plan (the resident) had a stage 3 on right lateral foot . Pressure ulcer will show improvement through next review. Date Initiated: 11/09/2023 . Air mattress on bed and extender Date Initiated: 11/09/2023 . Low profile cushion to Broda chair Date Initiated: 11/09/2023 . Observe for sliding down in the chair and assist to reposition in chair as needed. Date Initiated: 11/22/2023 . Prafo boots on at all times off for showers Date Initiated: 11/09/2023 . Treatment to pressure ulcer, right lateral foot per physicians order. Date Initiated: 11/22/2023 .</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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the (the resident) has a functional ability deficit and requires assistance with self care/mobility R/T (related to): Impaired Balance and Impaired Cognition Date Initiated: 10/04/2023 . Goal Mobility Will maintain current level of function in Roll left and right . Chair/bed to chair transfer . Interventions . AMBULATION: (the resident) is unable to ambulate and requires a Broda chair with right side lateral support. Bolster attached to right chair handle for positioning. Blue padded foot buddy on Broda chair. BED MOBILITY: (the resident) requires 2 assist to reposition and turn in bed. Date Initiated: 04/03/2024 . TRANSFER: (the resident) requires 2 assist Hoyer lift with transfers Date Initiated: 04/03/2024 .</p> <p>A review of the Physician's orders revealed an order for Enhanced Barrier Precautions Start Date: 03/26/2024.</p> <p>A review of the care plan (the resident) is on Enhanced Barrier Precautions related to: chronic wound Date Initiated: 03/29/2024 . Prophylactic prevention of spreading an infection to the wound: Enhanced Barrier Precautions . Interventions Gloves, gown, alcohol-based sanitizer (masks and face shields if needed), readily available for high-contact resident care Date Initiated: 03/29/2024 .</p> <p>On 4/03/24, at 10:00 AM, Upon entering Resident #18's room, there was still no isolation caddy, gowns or sign on the doorway. Resident #18 was assisted to their reclining Broda chair with the assistance of CNA C and CNA D. Resident #18 did not have a dressing to their right foot and their pressure ulcer was exposed. CNA C offered that they had just assisted with a shower and that the nurse was headed in to put the dressing back on. CNA C positioned Resident #18's right foot for observation. There was an open wound to outside lateral right foot measuring approximately 1 centimeter (cm) wide by 1.5 cm long. The edges surrounding the ulcer appeared dried, yellow with a callus like appearance. There was an approximate depth of 0.5 cm to the center of the wound.</p> <p>On 4/03/24, at 10:13 AM, Therapy Staff (TS) E entered Resident #18's room and was asked if the resident was receiving therapy services and TS E stated, for maintenance on positioning and that they observe weekly to ensure proper positioning. TS E stated, that they ordered a full cushion inlay about two months back and were waiting on it.</p> <p>On 4/03/24, at 10:27 AM, Nurse A entered Resident #18's room with wound care supplies. Nurse A was concerned that it was a new wound as the CNA had reported it was the toe. Nurse A cleansed and treated the existing pressure ulcer to the right lateral foot per the physician's order. Nurse A was wearing gloves and no gown.</p> <p>On 4/03/24, at 1:00 PM, the facility was asked to provide a list of all residents in enhanced barrier precautions.</p> <p>On 4/03/24, at 1:05 PM, Resident #18 remained positioned in their reclining Broda chair.</p> <p>On 4/03/24, at 1:37 PM, Resident #18 was lying in their bed on their back.</p> <p>On 4/03/24, at 3:44 PM, Resident #18 remains in the same position on their back in bed.</p> <p>On 4/04/24, at 9:08 AM, Resident #18 was on lying on their back in bed. There was an isolation caddy to the doorway filled with PPE including gowns.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/04/24, at 10:00 AM, Nurse K was interviewed regarding Resident #18's facility-acquired pressure ulcer. Nurse K was asked if the resident was at risk for pressure ulcers and Nurse K stated, yes.</p> <p>A record review along with Nurse K of Resident #18's pressure ulcer treatment orders, measurements and skin evaluations/ulcer pictures revealed on 1/9/2024 the pressure ulcer was nearly healed; there was no depth to the wound the skin was closed. The 2/7/2024 picture revealed moderate amount of yellow slough to center of ulcer with an open area of 3 cm by 3 cm. The depth of the wound was immeasurable due to the moderate amount of yellow slough. Nurse K stated, that they had the wound almost healed but then was off sick and when they came back it had worsened.</p> <p>A record review of the TREATMENT ADMINISTRATION RECORD 2/1/2024 - 2/29/2024 . along with Nurse K revealed the following missed treatments: Tue 14 Sat 24 Sun 25 Wed 28 Thu 29 A review of the TREATMENT ADMINISTRATION RECORD 3/1/2024 - 3/31/2024 along with Nurse K revealed the following missed treatments: Sat 10 Sun 11. Nurse K was asked who completes wound measurements and care while they were not working and Nurse K stated, the scheduled nurses working the halls.</p> <p>On 4/04/24, at 10:10 AM, the Director of Nursing (DON) was interviewed regarding Resident #18's facility-acquired pressure ulcer and the DON offered that because the resident had contractures the ulcer was unavoidable and that therapy is now working with her.</p> <p>A review of the facility provided Skin Management Last Revised 7/14/2021 Policy revealed Guests/residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes . Upon admission/re-admission all guests/resident are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic medical record . Appropriate preventative measures will be implemented on guests/residents identified at risk and the interventions are documented on the care plan .</p> <p>Resident #30:</p> <p>On 4/2/2024 at 12:42 PM, Resident #30 was observed finishing his lunch and watching television. This writer observed Prafo boots in the room and asked the resident about them. he explained he wears them only when he is in the bed as a wound developed on his heel at the facility. Resident #30 stated during his shower an aide noticed it and retrieved the nurse for further assessment. The wound is on the bottom of his left heel, but it has not caused him any discomfort.</p> <p>On 4/3/2024 at 10:00 AM, this writer observed Unit Manager B perform wound care on Resident #30's pressure ulcer. The wound was located on the side of the left heel, 100% eschar covered, circular and not able to be staged.</p> <p>On 4/3/2024 at approximately 11:00 AM, a review was conducted of Resident #30 medical records, and it indicated he admitted to the facility on [DATE] with diagnoses that included Acute Posthemorrhagic Anemia, Atrial Fibrillation, Acute Kidney Failure, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting left non-dominant side. Resident #30 is cognitively intact and able to make his needs known to facility staff. Resident #30 utilized a motorized wheelchair, required substantial assistance for lower body dressing/rolling left and right/putting on/taking off footwear. Further review of Resident #30's medical records yielded the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Admission Assessment 2/16/2024:</p> <p>Per the skin assessment section there was bruising noted on his bilateral upper extremities, blanchable area on buttocks/coccyx, open area on distal left buttock and open area on proximal left buttocks. There was no open area on Resident #30's left heel upon admission the facility.</p> <p>Practitioner Notes:</p> <p>There were no practitioner notes that indicated the physician or designee assessed or were aware of Resident #30's facility acquired pressure ulcer.</p> <p>Progress Notes:</p> <p>3/8/2024 at 14:43: .Unstageable blister to left heel (CVA side) measuring 3.83 x 3.4 cm (centimeters). Resident with inability to move left side of body due to CVA. Left hand is contracted</p> <p>3/2/2024 at 21:58: Skin Turgor: Good Elasticity . Number of new skin conditions: 0.</p> <p>2/24/2024 at 23:51: Skin Turgor: Good Elasticity .Number of new skin conditions: 0.</p> <p>Care Plan:</p> <p>(Resident #30) has unstageable pressure ulcer on left heel. He is at risk for additional impaired skin integrity/pressure injury R/T (related to): mobility deficit, weakness .</p> <p>Skin and Wound Evaluation:</p> <p>3/6/2024:</p> <p>-Facility acquired unstageable pressure ulcer on left heel. Found on 3/6/2024 with measurements of 9.4 cm x 3.8 cm x 3.4 cm. Wound is 100% eschar and it indicated facility practitioner was notified of the wound. Cleanse wound with normal saline/wound cleanser, pat dry with 4x4's, apply skin prep and leave open to air daily.</p> <p>3/13/2024:</p> <p>-8.2 cm x 3.8 cm x 3.0 cm, 100% eschar, unstageable with same treatment in place</p> <p>3/20/2024:</p> <p>-8.2 cm x 3.8 cm x 3.1 cm, 100% eschar, unstageable with same treatment in place</p> <p>3/28/2024:</p> <p>-8.1 cm x 3.3 cm x 3.3 cm, 100% eschar, unstageable with same treatment in place</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/4/2024 at 12:10 PM, an interview was conducted with the DON (Director of Nursing) and Wound Nurse K regarding Resident #30's facility-acquired pressure ulcer. Wound Nurse K shared that Certified Nursing Assistant (CNA) alerted her on 3/6/2024 to the new development and she assessed and took pictures. The resident had no pain or discomfort and upon discovery they initiated the Prafo boot while in bed. They were asked how the wound developed and it was explained the wound is on his stroke-affected side, which has poor circulation. When he lays in bed, his feet turn outward and that is where the wound developed. Prior to discovery there were no interventions in place while in bed to prevent development of the wound.</p> <p>39059</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>38471</p> <p>Based on observation, interview, and record review the facility failed to administer one resident's (Resident #57) morning medications on their scheduled dialysis days, resulting in Resident #57 not being administered approximately 62 doses of scheduled medication on the days that the resident received dialysis.</p> <p>Findings Include:</p> <p>Resident ##57:</p> <p>On 4/2/2024 at 12:47 PM, Resident #57 was observed in his room after finishing lunch. He reported he is currently on restrictions for food and liquids. He has dialysis three times a week on Monday, Wednesday and Friday and the facility transport him to/from about 6:30 AM for his 7:00 AM chair time.</p> <p>On 4/3/2023 at approximately 10:30 AM, a review was completed of Resident #57's medical records and it indicated he was admitted the facility on 3/11/2024 with diagnoses that included, End Stage Renal Disease, Atrial Fibrillation, Acute Cholecystitis, Heart Failure and Anxiety. Further review of Resident #57's records revealed the following:</p> <p>Care Plan:</p> <p>Administer medications as ordered. Observe for side effects and ineffectiveness, report abnormal findings to the physician .For Hemodialysis: Facility will utilize the Dialysis Communication form to communicate with the dialysis center. Send the dialysis communication book to the dialysis center with each appointment. Upon return from the dialysis center review the communication book including any progress notes. Provide an update to the physician and any staff member/disciplines as needed .</p> <p>MAR (Medication Administration Record):</p> <p>Medications ordered for administration at 8:00 AM and Noon were not provided to Resident #57 over 60 times as he was at dialysis. There was no documentation found that indicated it was provided upon his return from dialysis, communication with the physician regarding missed doses or a plan to ensure administration of medications either prior to or upon return from dialysis.</p> <p>March 2024 MAR (Medication Administration Record):</p> <p>Midodrine HCL 5 MG (milligram)- two missed doses</p> <p>Renal Oral capsule 1 MG - five missed doses</p> <p>Pantoprazole Sodium Oral Tablet 40 MG- five missed doses</p> <p>Apixaban Oral Tablet 2.5 MG- five missed doses</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/20/2024 at 07:25: eMar - Medication Administration Note</p> <p>Note Text: Unable to administer due to Res is on LOA at dialysis: Apixaban Oral Tablet 2.5 MG Give 2.5 mg by mouth two times a day for A-fib.</p> <p>3/20/2024 at 07:26:eMar - Medication Administration Note</p> <p>Note Text: Unable to administer due to Res is on LOA at dialysis: Midodrine HCl Oral Tablet 5 MG Give 5 mg by mouth one time a day every Mon, Wed, Fri for Hypotension.</p> <p>3/20/2024 at 07:27: eMar - Medication Administration Note</p> <p>Note Text: Unable to administer due to Res is on LOA at dialysis: Polyethylene Glycol Powder. Give 17 gram by mouth two times a day for Constipation.</p> <p>3/20/2024 at 07:27: eMar - Medication Administration Note</p> <p>Note Text: Unable to administer due to Res is on LOA at dialysis: Sennosides Tablet 8.6 MG. Give 2 tablet by mouth two times a day for constipation.</p> <p>3/20/2024 at 11:00: eMar - Medication Administration Note</p> <p>Note Text: Unable to administer due to Res is on LOA at dialysis: HCl Oral Tablet 800 MG Give 2 tablet by mouth with meals for Kidney failure.</p> <p>3/20/2024 at 11:00: eMar - Medication Administration Note</p> <p>Note Text: Unable to complete the following treatment due to Res is on LOA at dialysis: Empty and measure JP drain TID right side three times a day for JP drain.</p> <p>3/20/2024 at 12:00: eMar - Medication Administration Note</p> <p>Note Text: Unable to administer due to Res is on LOA at dialysis: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligram) /3ML (milliliter).</p> <p>3/20/2024 at 12:26: eMar - Medication Administration Note</p> <p>Note Text: Unable to administer due to Res is on LOA at dialysis: Pantoprazole Sodium Oral Tablet Delayed Release 40 MG.</p> <p>3/27/2024 at 09:14 AM, 09:15, 09:16, 09:17, 09:18, 09:18: eMar-Medicament Administration Note: at dialysis.</p> <p>3/29/2024 at 07:42: unable to administer due to Res is on LOA at dialysis: Apixban Oral tablet 2.5 mg.</p> <p>3/29/2024 at 07:43: Unable to administer due to Res is on LOA at dialysis: Metoprolol Tartrate oral tablet 25 MG.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>39059</p> <p>Based on record review, the facility failed to provide timely physician's visits for one resident (Resident #15), resulting in a lack of a physician's 60-day follow-up visit, with the likelihood of decreased quality of care and missed assessments of health changes.</p> <p>Findings include:</p> <p>Resident #15:</p> <p>On 4/02/24, at 11:35 AM, a record review of Resident #15's electronic medical record revealed an admission on 2/26/2016 with diagnoses that included Chronic Pulmonary Obstructive Disease, Hypertension and Anxiety.</p> <p>A review of the physician visits revealed the last visit was documented on Date of Service: 1/19/24 Visit Type: Acute'. There were no documented physician visits from 1/19/2024 thru survey exit 4/4/24.</p> <p>A review of the facility provided Physician Services Last Revised 2/22/2022 Policy revealed . Each guest/resident must be seen by their physician at least every 30 days for the first 90 days after admission, and then every 60 days thereafter . A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Lakeview Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  408 N Fifth Ave Tawas City, MI 48763	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>39059</p> <p>Based on interview and record review, the facility failed to ensure a that Pharmacy Regimen Review was acted upon for one resident (Resident #15), resulting in a delay of the pharmacy recommendation of a fasting (nothing to eat or drink for 8 to 12 hours beforehand) lab test with the likelihood of unwanted side effects and/or ineffectiveness of the medication going unmonitored.</p> <p>Findings include:</p> <p>Resident #15:</p> <p>On 4/02/24, at 11:35 AM, a record review of Resident #15's electronic medical record revealed an admission on 2/26/2016 with diagnoses that included Chronic Pulmonary Obstructive Disease, Hypertension and Anxiety.</p> <p>A review of the Medication Regimen Review - Pharmacy Date: 2/5/2024 revealed the box was check marked for See report for noted irregularities and/or recommendations.</p> <p>A review of the Consultation Report . Recommendation date: 02/05/2024 . Comment: (Resident #15) receives Atorvastatin Calcium and does not have a fasting lipid panel documented in the medical record in the previous 12 months. Periodic lipid monitoring is recommended to evaluate effectiveness and to assist in adjusting medication therapy to the individual treatment plan. Recommendation: Please monitor a fasting lipid panel on the next convenient lab day and every 12 months thereafter . The line with the physician name had a signature and was dated 2/6/24.</p> <p>A review of the Consultation Report . Recommendation date: 03/11/2024 . Comment: (Resident #15's) prescriber accepted a pharmacy recommendation to draw lipid panel on 2/6/24, but the order has not yet been processed. (no order or lab result in (PCC) Recommendation: Please process the accepted pharmacy recommendation and update the medical record accordingly.</p> <p>A review of the third Consultation Report . Date: 04/02/2024 . Comment: (Resident #15) prescriber accepted a pharmacy recommendation to draw lipid panel on 2/6/24, but the order has not yet been processed . Recommendation: Please process the accepted pharmacy recommendation and update the medical record accordingly. There was a written message Lab ordered 4-3-24.</p> <p>A review of the facility provided lab result BLOOD Collected 03/18/2024 14:55 (2:55 PM) revealed the lab was drawn in the middle of the afternoon and was not a fasting lipid panel blood test.</p>		

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NAME OF PROVIDER OR SUPPLIER  Lakeview Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  408 N Fifth Ave Tawas City, MI 48763	

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38471</p> <p>Based on observation, interview, and record review the facility failed to document clinical rationale for the usage of duplicate drug therapy for one resident (Resident #40) of four residents reviewed for unnecessary medications, resulting in Resident #40 being prescribed dual antipsychotic and antidepressant medications in the absence of appropriate documentation that clarified the rationale for and benefits of duplicate therapy.</p> <p>Findings Include:</p> <p>Resident #40:</p> <p>During initial tour on 4/2/2024, Resident #40 was observed ambulating through the hallway and speaking with facility staff. He was not able to be interviewed due to his disease process but appeared to be in good spirits.</p> <p>On 4/2/2024 at approximately 3:30 PM, a review was conducted of Resident #40's medical records and it indicated he admitted to the facility on [DATE] with diagnoses that included Alcohol Dependence with Alcohol Induced persisting dementia, Bipolar Disorder, Major Depressive disorder, Anxiety Disorder, Alcoholic Cirrhosis of the liver, Atrial Fibrillation. Further review was completed of Resident #40's chart and it indicated the following:</p> <p>Physician Orders:</p> <p>Mirtazapine Tablet 30 MG (milligram) - give one table by mouth at bedtime for depression/sleep</p> <p>Olanzapine Oral Tablet 20 MG- give by mouth one time a day for bipolar disorder.</p> <p>Seroquel Oral Tablet 50 MG- give by mouth one time a day for psychosis.</p> <p>Seroquel XR Oral Tablet Extended Release 24 Hour 200 MG- give by mouth at bedtime for psychosis</p> <p>Zolof Tablet 100 MG- give 2 tablets by mouth one time a day for behavior.</p> <p>Resident #40 is prescribed dual antidepressants (Mirtazapine and Zolof) and dual antipsychotic's (Seroquel and Olanzapine).</p> <p>Care Plan:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Lakeview Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  408 N Fifth Ave Tawas City, MI 48763	
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>. (Resident #40) has the potential for fluctuations in mood R/T: DX: BiPolar DO, Anxiety. He is easily agitated, becomes verbally and physically aggressive with staff and others if they get in his way or redirect him. He swears, and threatens staff, may throw things. He is not easily redirected. He often does not like being touched. Behavior Monitoring 1: in and out of rooms, abusive language, threatening, physically and verbally abusive to staff, refusing care, wandering, exit seeking, masturbating in public areas . (Resident #40) has the potential to demonstrate both physical, verbal aggression aeb: throwing toilet tank lid on floor and smashing it, using foul language with staff and peers, pushing staff across the room, threatening staff with silverware, raising his fist etc. R/T: Anger, Depression, Ineffective coping skills, Mental Illness, Poor impulse control; alcoholic withdrawals, depressive disorder, hx of non-compliance with medication. He does not take direction/redirection well .</p> <p>Practitioner Notes:</p> <p>There were no practitioner notes (medical or behavioral) that indicated the rationale for the current duplicate antidepressant and antipsychotic drug usage.</p> <p>On 4/4/2024 at 9:45 AM, an interview was conducted with Social Work Director J regarding Resident #40's duplicate therapy and current behavior management plan. Director J explained the resident has experienced recent documented events of outward aggression toward staff, change in his sleep pattern when he wandered into residents' rooms at night causing them distress, easily frustrated and not always easily redirectable. Resident #40 had physically pushed staff, used threatening/abusive language staff and they have been working to stabilize him on his current medication regime. Director J was asked if the physician or contracted behavior health provider documented the rationale for duplicate therapy anywhere in his chart. Director J stated she would search Resident #40's record for the requested information. Prior to conclusion of the survey, Director J was not able to locate any documented clinical rationale related to Resident #40's duplicate antidepressant and antipsychotic medication usage in his record.</p> <p>Review was completed of the facility policy entitled, Psychoactive Medication Management, revised 10/20/2023. The policy stated, .Duplicate therapy refers to multiple medications of the same pharmacological class/category or any medication that substantially duplicates a particular effect of another medication that the individual is taking .when pharmacological interventions are indicated, the licensed staff will verify that the physician order includes the appropriate clinically supported diagnosis and/or behavior symptoms. Verify medication name, dose, duration, clinical symptoms for use and diagnosis .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39059</p> <p>Based on observation, interview and record review, the facility failed to alert staff and visitors of Enhanced Barrier Precautions in a timely manner and follow Enhanced Barrier Precautions during a medical treatment for one resident (Resident #18), resulting in wound care being completed with no gown and the likelihood of cross contamination and spread of infections causing bacteria.</p> <p>Findings include:</p> <p>Resident #18:</p> <p>On 4/02/2024, at 9:30 AM, Resident #18 was resting in their bed. There was no isolation caddy nor sign on the door.</p> <p>On 4/02/2024, at 2:30 PM, a record review of Resident #18's electronic medical record revealed a readmission on 07/27/2023 after a short hospital stay with diagnoses that included Diabetes, weakness and Dementia. Resident #18 required extensive assistance with Activities of Daily Living (ADL's) and had severely impaired cognition.</p> <p>A review of the Physician orders revealed an order for Enhanced Barrier Precautions Start Date: 03/26/2024.</p> <p>A review of the care plan (the resident) is on Enhanced Barrier Precautions related to: chronic wound Date Initiated: 03/29/2024 . Prophylactic prevention of spreading an infection to the wound: Enhanced Barrier Precautions . Interventions Gloves, gown, alcohol-based sanitizer (masks and face shields if needed), readily available for high-contact resident care Date Initiated: 03/29/2024 .</p> <p>On 4/03/24, at 10:00 AM, Upon entering Resident #18's room, there was still no isolation caddy, gowns or sign on the doorway. Resident #18 was assisted to their reclining Broda chair with the assistance of CNA C and CNA D. Resident #18 did not have a dressing to their right foot and their pressure ulcer was exposed. CNA C offered that they had just assisted with a shower and that the nurse was headed in to put the dressing back on. CNA C positioned Resident #18's right foot for observation. There was an open wound to outside lateral right foot measuring approximately 1 centimeter (cm) wide by 1.5 cm long. The edges surrounding the ulcer appeared dried, yellow with a callus like appearance. There was an approximate depth of 0.5 cm to the center of the wound.</p> <p>On 4/03/24, at 10:27 AM, Nurse A entered Resident #18's room with wound care supplies. Nurse A was concerned that it was a new wound as the CNA had reported it was the toe. Nurse A cleansed and treated the existing pressure ulcer to the right lateral foot per the physician order. Nurse A was wearing gloves and no gown.</p> <p>On 4/04/24, at 9:08 AM, Resident #18 was on lying on their back in bed. There was an isolation caddy to the doorway filled with PPE including gowns.</p>		