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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235522 | A. Building<br>B. Wing | 03/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hillcrest Nursing and Rehabilitation Community | 695 Mitzi St<br>North Muskegon, MI 49445 |

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 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101<br><br>Based on observations, interviews, and record review, the facility failed to develop and implement a meaningful activities program for 4 Residents (R1, R2, R3 and R4) of 4 residents sampled, resulting in residents sitting unsupervised and experiencing boredom without the option for diversional activities to decrease the risk of injury.<br><br>Findings included:<br><br>R4<br><br>Review of R4' face sheet (no date) revealed she was a [AGE] year-old female admitted on [DATE] and had diagnoses that included: dementia, glaucoma, need for assistance with personal care, repeated falls, and muscle weakness. R4 was not her own responsible party.<br><br>During an observation on 4/17/24 at 1:37 PM, R4 sat in a wheelchair near the nurse's station. R4's feet were on footrests. R4 was not able to move her wheelchair or answer any questions. R4 grimaced as if she was in pain and rubbed her right leg. Staff moved about the unit. At times, staff were not in sight. There were no activities for the residents sitting near the nurse's station. Other residents in the area also appeared to be confused and had no activities provided.<br><br>Review of R4's ADL (activities of daily living) care plan dated 1/17/24 revealed approach's that included: 4/15/24, for assistance of 1 person for walking with a 4 wheeled walker. 4/15/24 transfer assist of 1 person. 9/13/23, toileting assistance 1 person. 1/17/21, bed mobility independent. (no interventions were located for bed/chair alarms, 15-minute checks or 1:1, and nothing indicated for need of supervision for safety identified).<br><br>Review of R4's fall care plan dated 1/17/21 revealed that R4 does not always alert staff to needs and requires one assist with transfer/ambulation related to history of falls with fractures. Approaches listed did not include interventions for supervision or diversional activities to increase supervision for increased safety.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235522 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/11/2024 |
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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with Regional Clinical Nurse (RCN) A on 4/17/24 at 5:25 PM, she confirmed that R4's care plan did not include the 1:1, 15-minute checks, alarms for her safety, or the need for assistance with ambulation and transfers after a fall on 3/20/24. RCN A stated the team would evaluate R4 upon her return from a medical appointment but did not know what interventions they would implement. Upon survey exit, staff did not put any new interventions into place for R4's safety. RCN A said when R4 fell on [DATE] she should have been on 1:1 care and that they educated the nurse that changed R4 to 15-minute checks. (Upon survey exit, the facility did not provide documentation of this education). RCN A was not able to provide any information or documentation of an activities program when asked about activities and supervision for all the facility residents with cognitive impairments and poor safety awareness. The facility currently did not have an activity director or aide on staff.<br><br>R1<br><br>Review of R1's face sheet (no date) revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: fracture of right femur, cerebral infarction (stroke), unsteady on feet, vascular dementia, need for assistance with personal care, difficulty in walking, and altered mental status. No indication of a guardian or durable power of attorney was located.<br><br>Review of R1's Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview of Mental Status (BIMS) score of 6/15 (severely cognitively impaired).<br><br>During an observation on 4/17/24 at 8:30 AM, R1 was sitting in front of the nurse's station. Staff were not consistently in the area as all staff were busy providing care or doing other tasks. R1 could not recall what activities she liked, and she did not know where she would go if she wanted something fun to do.<br><br>During an interview with Licensed Practical Nurse (LPN) C on 4/17/24 at 8:37 AM, he named the 4 residents sitting at the nurse's station and responded to questions of whether they were there for any reason by saying they took themselves there and they can move about the facility at will. LPN C said he was not aware of any activities available for the residents at this time but said sometimes staff do provide activities in the main dining area. LPN C was not aware of any safety concerns for R1 or the other 3 residents sitting at the nurses' station.<br><br>Review of R1's ADL (activities of daily living) care plan dated 3/8/24 revealed, R4 has self-care deficits related to dementia, impaired balance, and right femur fracture. Approaches included: 3/27/24 check and change on or about every 2 hours d/t (due to) incontinence. 3/8/24 needs 1 assist for toileting/elimination, 1 assist for transfers and 1 assist for mobility with a walker, independent with wheelchair mobility.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R1's fall care plan dated 1/25/24 revealed she was at risk for falls related to impaired balance, not always aware of safety needs and multiple medical diagnoses. Approaches included: 3/26/24 while awake offer diversional activities - examples magazines, music fiddle objects and television. 3/22/24 reassess toileting needs. 3/1/24 round on resident on or about every hour to ensure nonskid footwear in place, assist with toileting needs if indicated and ensure brief on resident. 1/25/24 assess for residents' participation in bowel and bladder program. 4/17/24, R1 prefers independent activities in her room or to be in the public area; she does not want constant staff oversight. Provide diversional activities of choice such as baby doll, stress balls, snack, or drink. 4/17/24 offer R1 assistance with toileting on or about every 2 hours while awake to promote continence.<br><br>During an interview with the facility care team for R1 on 4/17/24 at 2:45 PM, the facility Social Worker (SW) J said she met with R1 today and she prefers no supervision. SW J denied any offering of supervision or risk/benefits when asked if the facility offered supervision and risk/benefits or if they discussed them with R1 or her advocate/or guardian. SW J said R1's Brief Interview of Mental Status score was 6 and her physician had determined she was not competent, but the facility requested a second physician review for competency and a second physician has not completed that review yet. SW J had no idea when the second physician would address her competency and could not verify R1 understood the risks when she had the conversation. Regional Director of Operations B directed SW J to contact the second physician to evaluate R1's competency. Upon exit, the facility did not provide a risk benefit statement or any assurance that R1 could understand the risks related to lack of supervision. The facility did not provide any documentation that they changed R1's care plan to reflect supervision needed to ensure her safety.<br><br>During an interview with the facility care team for R1 on 4/17/24 at 2:45 PM, they were unable to provide any information on how they were supervising R1 when she was awake. They had no documentation to indicate if staff were offering R1 diversional activities and no activity calendar was located for April 2024.<br><br>R2<br><br>Review of R2's face sheet (no date), revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: cerebral infarction (stroke), fracture of left pubis (pelvic bone), unsteady on feet, and muscle weakness. She was not her own responsible party.<br><br>During an observation on 4/17/24 at 8:30 AM, R2 sat in her wheelchair at the nurse's station. Staff were not always in the area as they were caring for other residents. No activities occurring at that time. R2 could not say what activities she liked or where the facility had activities.<br><br>During an interview with Licensed Practical Nurse (LPN) C on 4/17/24 at 8:37 AM, he named the 4 residents sitting at the nurse's station and responded to questions of whether they were there for any reason by saying they took themselves there and they can move about the facility at will. LPN C said he was not aware of any activities available for the residents at this time but said sometimes staff do provide activities in the main dining area. LPN C was not aware of any safety concerns for R1 or the other 3 Residents sitting at the nurses' station.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R2's fall care plan dated 10/31/23 revealed, R2 is at risk for falls related to impaired balance, weakness and does not always comply with the use of call light to alert staff of needs and will self-transfer/ambulate. The care plan also listed multiple medical diagnoses as risk factors for her falls. Approaches included: 4/2/24, keep alarm box out of reach. 3/27/24, will attempt self-transfers, follow toileting routine as outlined and documented. 3/26/24 toilet before and after meals, upon rising and prior to bed. Also, toilet or check and change on or about 2 AM per bowel and bladder study. 3/22/24 occupy with meaningful distractions music, companion, diversional activity per resident preference, resident enjoys sitting in common area socializing with other residents and staff. 3/22/24 reassess toileting needs. 3/22/24 staff to round on resident on or about hourly when she is in her room related to resident's history of self-transferring.<br><br>R3<br><br>Review of R3's face sheet (no date), revealed she was an [AGE] year-old female admitted on [DATE] and had diagnoses that included: severe protein-calorie malnutrition, need for assistance with personal care, muscle weakness, difficulty in walking, cognitive communication deficit, dementia, and compression fracture of lumbar vertebra. She was not her own responsible party.<br><br>During an observation on 4/17/24 at 8:30 AM, R3 sat in her wheelchair at the nurse's station. Staff were not always in that area as they were attending to other residents. No activities occurring at that time. R3 could not say what activities she liked or where the facility had activities.<br><br>During an interview with Licensed Practical Nurse (LPN) C on 4/17/24 at 8:37 AM, he named the 4 residents sitting at the nurse's station and responded to questions of whether they were there for any reason by saying they took themselves there and they can move about the facility at will. LPN C said he was not aware of any activities available for the residents at this time but said sometimes staff do provide activities in the main dining area. LPN C was not aware of any safety concerns for R1 or the other 3 Residents sitting at the nurses' station.<br><br>Review of R3's ADL (activities of daily living) care plan dated 12/20/23 revealed she requires assistance with ADL's related to dementia, requires cues and assistance to complete ADL/mobility tasks, impaired balance and weakness, Approaches included: 3/22/24 resident is impulsive and will attempt to self-transfer, 12/20/23, toilet/elimination needs 1 assist. 12/20/23, mobility 1 assist to ambulate. 12/20/23, transfers 1 assist.<br><br>During an interview with the Regional Director of Nursing (RDN) A on 4/17/24 at 2:45 PM, RDN A acknowledged R3's self-transferring and walking without assistance and said the facility trained the husband and that he is safe to assist at this time. RDN A could not say what supervision interventions were in place when R3's husband was not in the room. RDN could not provide any documentation of diversional activities attempted and there was no activity calendar for April.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with the facility treatment team that included the Nursing Home Administrator (NHA), Interim Director of Nursing (IDON), Regional Clinical Nurse A and Regional Director of Operations (RDO) B on 4/17/24 at 2:45 PM., the facility could not provide current information on any activity program designed for their dementia residents that would allow diversional activities, quality of life, or supervision for the residents that wander and have unsafe behaviors. They acknowledged they were making attempts to provide some activities utilizing the Certified Nurse Aides (CNA) and Licensed Nurses. They currently had no activity staff employed. They did not have a calendar or any scheduled activities for the month of April. They were unable to provide documentation for R1, R2, R3 or R4 showing that the facility offered activities. They confirmed that all 4 residents lacked safety awareness and were unpredictable with when they would attempt to self-transfer. Facility staff offered all 4 residents the toilet or having a brief change every 2 hours and staff checked on them every 1 to 2 hours. They were still attempting to self-transfer or take themselves to the bathroom. The facility did not indicate when they would have diversional activities available on a routine basis to ensure dementia residents had supervision and/or assistance when needed to improve their quality of life. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101<br><br>Based on observations, interviews and record review, the failed to provide adequate supervision to prevent falls for 3 Residents (R1, R2, and R3) of 3 residents reviewed for falls, resulting in R1 falling and sustaining a hip fracture and the potential for R2 and R3 to sustain serious injuries.<br><br>Findings included:<br><br>R1<br><br>Review of R1 face sheet, no date, revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: cerebral infarction (stroke), vascular dementia, psychotic disturbance, mood disturbance, anxiety, need for assistance with personal care, muscle weakness, difficulty in walking, cognitive communication deficit, syncope (fainting) and collapse.<br><br>Review of R1's Brief Interview of Mental Status (BIMS) dated, 1/30/24 revealed she scored 6/15 (severe cognitive deficit).<br><br>Review of R1's incident and accident report dated 2/26/24 at 6:30 AM revealed, R1 had an unwitnessed fall that was discovered after shift change on 2/26/24 at 6:30 AM that resulted in a hip fracture. When R1 was found on the floor she did not have a brief on or proper footwear. The care plan was reviewed and revealed she required 1 assist and had decreased safety awareness that contributed to her fall.<br><br>During a review of a facility interview dated 2/26/24, Certified Nurse Aide (CNA) C revealed CNA C was assigned to R1 prior to R1 being found on the floor. The report revealed CNA C had observed R1 moving around her room at night, she has had to put new briefs on R1 and cleaned up urine off R1's floor. CNA C reported R1 was naked in bed at 12:30 AM and at 4:00 AM, R1 was in bed.<br><br>R1 was observed sitting in a wheelchair in front of the nurse's station on 3/11/24 at 8:32 AM. R1 was not able to answer any questions. R1 was sitting with 6 other residents. All residents were facing the nurses' station. No staff were in eye contact with the 7 residents or at the nurses' station. The residents were sleeping or just looking at the nurses' station.<br><br>During an interview with Certified Nurse Aide (CNA) B on 3/11/24 at 8:38 AM, CNA B said she cared for R1 prior to her fall that resulted in a hip fracture. CNA B said R1 frequently self-transferred, and she would just try to do frequent checks on her when she was awake. CNA B said she did know she had to check on her when her door was closed. CNA B said she always leaves R1's door open when she puts her to bed and R1 frequently got herself out of bed and shut her door. CNA B said they do not have any staff designated to watch the dementia residents that wander or self-transfer. CNA B denied any documentation requirements for unsafe behaviors.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a telephone interview with the Director of Nursing (DON) and CNA C on 3/11/24 at 10:17 AM, CNA C confirmed that she provided care for R1 the night of 2/26/24 and she left at 6:00 AM. CNA C was not aware that R1 was on the floor when she left work. CNA C said R1 is generally awake at least half the night shift. She confirmed she assisted R1 at 12:30 AM when she was naked in bed, and she saw her in bed at 4:00 AM. CNA C did not observe R1 after 4:00 AM that night. CNA C said R1 self-transfers all the time and walks about unassisted at times. R1 was known to get out of bed and remove her wet brief. CNA C denied any knowledge of a toilet schedule for R1. R1 said they only have 2 CNA's and 1 nurse on the night shift for 36 residents. R1 said at least 5 of the residents including R1 are up during the night shift, and they are not safe left alone and 3 staff cannot supervise all the awake residents and provide for all the other care needs. CNA C said she has reported this concern to management on multiple occasions, but no one does anything.<br><br>Review of R1's fall care plan dated 1/25/24 revealed, interventions that included: Assess for need of resident's participation in bowel and bladder program and provide assistance to toilet as needed. There was no indication of how staff were to provide supervision when R1 was awake.<br><br>Review of R1's progress note dated 2/26/24 at 6:30 AM revealed, Res (resident) was observed shivering on the floor surrounded and saturated with urine (resident's hair, body/gown were all soaked). When asked what happened res (resident) states that she had to use the bathroom. When asked how long she had been there resident states all night.<br><br>Review of R1's progress note dated 2/11/24 at 9:03 AM revealed, Res (resident) alert and pleasant with confusion at her baseline. Walks occasionally with walker, gait is unsteady. She uses the wc (wheelchair) for long distance Denies SOB (shortness of breath) no issues with respiratory distress reported or observed. Incont (incontinent) of B & B (bowel and bladder). She does have poor safety awareness and has been observed ambulating without assistance.<br><br>During an interview with the DON and Corporate Nurse (CN) A on 3/11/24 at 11:17 AM, they confirmed that there were only 3 staff working on the night shift and they did not have a program in place to supervise the dementia residents that had unsafe behaviors (walking unassisted, wandering and self-transfers). They confirmed that the staff were not consistently documenting the unsafe behaviors. They were unable to locate any documentation on R1's wake/sleep cycle or toilet pattern. They reported that they were in process of developing a program and the program would be educated on and put in place today that would start tracking wake/sleep/toilet needs and have activities to assist in supervising the dementia residents when they were awake.<br><br>R2<br><br>Review of R2's face sheet, no date, revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: cerebral infarction (stoke), fracture of left pubis (pelvic bone), unsteady on feet, need for assistance with personal care, and memory impairment. R2 was not her own responsible party.<br><br>R2 was observed on 3/11/24 at 12:45 AM moving her wheelchair down the hall independently with no staff in eyesight of her. R2 was not able to answer questions.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview with CNA H on 3/11/24 at 12:47 PM, CNA H said she was assigned to R2 at this time. CNA H said R2 is not able to tell staff when she needs help and is known to self-transfer and fall. R2 was asked how the facility provides supervision for R2. CNA H said they do not have anyone assigned to provide supervision; she just tries to do frequent checks.<br><br>Review of R2's ADL (Activities of Daily Living) care plan dated 10/31/23, revealed she required assist of 1 for toilet use and transfers.<br><br>Review of R2's fall care plan dated 10/31/23 revealed she was at risk of falls related to impaired balance with transitions, lower extremity weakness, hypertension with use of antihypertensive medications with potential for fluctuations in blood pressure, diuretic medications use, glaucoma, peripheral vascular disease, osteoporosis, osteoarthritis, does not always comply with use of call light to alert staff of needs and will self-transfer/ambulate. There were no interventions listed to supervise R2 when she was awake. There was no indication of her sleep/wake cycle or toilet schedule.<br><br>Review of the facility timeline for R2's falls between 2/6/24 and 11/25/23 revealed R2 had 3 unobserved falls (R2 was not being supervised at the time of these falls). Interventions placed did not include any interventions to supervise R2 when she was awake.<br><br>R3<br><br>Review of R3's face sheet, no date, revealed she was an [AGE] year-old female admitted on [DATE] and had diagnoses that included: severe protein-calorie malnutrition, need for assistance with personal care, muscle weakness, difficulty in walking, cognitive communication deficit, dementia, and compression fracture of lumbar vertebra. She was not her own responsible party.<br><br>Review of R3's ADL (Activities of Daily Living) care plan dated 12/20/23 revealed she required assistance of 1 person to walk to the bathroom with a walker, 1 assist for transfers, and 1 assist to move about in her wheelchair.<br><br>Review of R3's fall care plan revealed she was at risk of falls related to dementia, impaired balance with transitions, weakness, incontinence and unaware of safety needs. There were no interventions related to how the facility planed to specifically supervise R3 when she was awake.<br><br>Review of the facility timeline for falls for R3 revealed R3 had an unobserved fall on 12/31/23 at 4:30 PM. R3's husband had not visited that day and R3 was looking for her husband.<br><br>On 3/11/24 at 12:51 PM, CNA B said R3 was currently assigned to her. CNA B said R3 will not walk with her walker or put her call light on. When R3's husband is not with her she tries to do frequent checks. R3 does not have any activities scheduled daily and no staff are assigned to watch her or other residents that self-transfer. CNA B was aware R3 was in her room and her husband was present today.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R3 was observed in bed on 3/11/224 at 12:52 PM and her husband was holding her hand. R3's husband said R3 fell several times at home and denied the facility offering any structured programs to supervise his wife daily. R3's husband said he comes every day to walk with her, take her to the bathroom when needed, and tries to keep her awake so she will sleep at night. He said her children come on the weekend to give him a break. Her husband confirmed R3 cannot use her call light and will not alert staff when she needs to use the bathroom. R3 smiled at her husband as he talked about her.<br><br>During an interview with the Nursing Home Administrator (NHA), Director of Nursing (DON) and Corporate Nurse (CN) A on 3/11/24 at 2:30 PM, the fall timelines for R2 and R3 were reviewed. They confirmed that the falls were not witnessed, both residents were known for unsafe transfers and walking, and the facility did not have structured activity plans for R1, R2 or R3. The DON just started and the NHA had started less than 2 months ago. CN A and the NHA said they just hired an activity aide that is starting this week and they had planned on providing more structured activities for the dementia residents. They were starting education today on monitoring residents wake/sleep and toilet schedules and implementing structured activities and supervision for residents with impaired safety. |