

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Oakland Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22401 Foster Winter Dr Southfield, MI 48075	

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 0578</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>This citation pertains to Intake #MI00141083</p> <p>Based on interview and record review, the facility failed to ensure Advance Directives (legal document which a person specifies their medical choices) information was correct for one resident (R801) of five reviewed for advance directives resulting in R801's initial wishes of Do Not Resuscitate (DNR) was not followed by the facility resulting in unnecessary full resuscitation measures (Cardiopulmonary Resuscitation (CPR), were performed. Findings Include:</p> <p>A concern to the State Agency (SA) implied R801 was transferred from the facility for emergent escalation of care and failed to provide the Emergency Medical Service (EMS) responders with DNR paperwork and CPR was performed.</p> <p>On [DATE], A clinical record review revealed R801 was transferred on [DATE] from the hospital and admitted to this facility with congestive heart failure, dyspnea (difficulty breathing), interstitial lung disease (term referring to many chronic lung diseases), and atrial fibrillation (irregular heartbeat). A Brief Interview for Mental Status score of ,d+[DATE] revealed R801 was cognitively intact.</p> <p>Record review of the Nursing Progress Note dated [DATE] at 5:20 AM, revealed R801 required an emergent transfer to the hospital for chest pain, and respiratory distress. A verbal Nursing report was provided to EMS and specified R801 was a Full Code (medical term meaning all procedures will be provided to keep a person alive and can include chest compressions and intubation). Upon arrival into the Emergency Department (ED) EMS informed the ED Providers that R801 was a full code and the decision by the ED Providers to intubate (placing a tube down into the throat to get oxygen into the lungs) was made. As the ED was preparing for intubation, R801 went into cardiac arrest (heart suddenly and unexpectedly stops beating) and CPR was initiated. R801 was intubated, required chest compressions, then placed on mechanical measures for life support. When the family arrived at the emergency department, it was revealed to the ED Providers that R801 was not a full code as reported by the facility to EMS, and original wishes were not to be resuscitated or intubated.</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 0578</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE], A record review of the facility advance directive form signed by R801 on [DATE], documented the choice to be DNR. The form was witnessed by the admitting Registered Nurse (RN) B on [DATE] and acknowledged by signature by Physician A on [DATE]. Further record review revealed the discharge paperwork from the hospital sent to admitting facility revealed R801's advance directives was DNR, no compression or shocks.</p> <p>When the Electronic Medical Record (EMR) for R801 was reviewed, a DNR order was not identified. R801 code status was documented as a full code. The full code order was entered on admission to the facility by Registered Nurse (RN) B on [DATE]. Physician A verified the full code order on [DATE].</p> <p>On [DATE] at 11:50 AM, An interview was conducted with the DON regarding R801's transfer to the hospital with an incorrect code status. The DON confirmed advance directives were not communicated correctly and the orders in the EMR were incorrect.</p> <p>On [DATE] at 2:10 PM, A phone interview with Physician A was conducted and indicated Nursing puts the orders into the computer but was not sure how they are reconciled. Regarding DNR elections by residents, Physician A denied documenting in the progress notes when DNR status is discussed with the resident. Physician A confirmed the DNR paper form is signed within 24 hours and places a DNR order (in the medical record).</p> <p>The Do Not Resuscitate Policy Number:180 stated: .The attending Physician must document in the resident's progress note why it has been determined that resuscitative measures should not be taken . Enter a formal written DNR order .</p> <p>The Facility Policy for Advance Directives Effective Policy Number:165 Effective ,d+[DATE] Revised [DATE] . [Facility] shall ensure that legally valid advanced directives and wishes are implemented, including transfer of an individual .</p>		