

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978</p> <p>This citation pertains to intake MI00142921.</p> <p>Based on observation, interview and record review, the facility failed to ensure dignified care experiences for three Residents (R36, R20 and R39) of four residents reviewed for dignity.</p> <p>Findings include:</p> <p>R36</p> <p>R36 was admitted to the facility on [DATE] and had diagnoses including stroke, aphasia (difficulty expressing and understanding speech), and hemiplegia (paralysis) and hemiparesis (weakness) affecting the right dominant side. A review of R36's Minimum Data Set (MDS) assessment, dated 3/19/2024, revealed R36 had intact long-term and short-term memory and required moderate independence [some difficulty in new situations only] with daily decision making. Further review of R36's MDS assessment revealed he required substantial/maximal assistance from staff to transfer to and from the toilet.</p> <p>An observation on 5/15/2024 at 12:31 p.m. revealed R36 seated in a wheelchair in his room facing the window. R36 was observed using his left arm to position his wheelchair toward the door. R36's right arm was tucked in close to his body with his right forearm resting on his lap. R36 conveyed he could not move his right arm or right leg. During an interview with R36 at the time of the observation, R36 was queried regarding toileting assistance. R36 pointed to the bathroom and then to the clock of the wall at the end of his bed. R36 was asked if he often had to wait in the bathroom for staff assistance after using the toilet. R36 was observed becoming visibly upset, nodding his head profusely while stating, yes, yes. When asked how long he had to wait on the toilet for staff assistance, he pointed to the clock again and said, all the way around. When asked if he was left sitting on the toilet for an hour before staff assisted him, R36 began nodding his head again while stating, yes, yes. R36 stated he just wanted to be treated like everyone else.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/2024 at 1:46 p.m., the Director of Nursing (DON) reported she was aware of an occurrence when R36 was left on the toilet for approximately 45 minutes after calling for assistance. The DON reported the incident occurred sometime last fall during the change of shifts from day shift to night shift. The DON reported when staff arrived to assist R36, he told them to go away because he was angry and had already called his brother to come to the facility to assist him. The DON stated an investigation was conducted to determine the reason R36 was left unassisted on the toilet. When asked how the call light system functioned, the DON reported when lights are activated from the bedside or in the bathrooms, a notice is sent to staff via a pager/phone and a light was activated in the hallway above the doorway of the respective room. The DON stated the call light notice went to Certified Nurse Aide (CNA) staff and if not answered/deactivated within around eight minutes, the notice would then be transmitted to nursing (Registered Nurse [RN]/Licensed Practical Nurse [LPN]) staff.</p> <p>A review of facility investigation documents titled [R36] Summary 9/19/2023 Event, revealed the following, in part:</p> <p>9/19/2023: Statement from [CNA I]. She placed resident on stool [toilet] around 6:15p/6:30p [6:15 p.m./6:30 p.m.] . Gave report around 6:30 [p.m.]/6:40 [p.m.]. Told the oncoming aide during report he was on the toilet. She finished report, took out the trash and then assisted putting another resident in bed and then punched out. [R36] had been difficult throughout the day, yelling down the hall and very demanding . Statement from [CNA M]. Received report approx. [approximately] 6:30 [p.m.]/7:00 [p.m.] . At around 7:15 [p.m.] I heard [R36] hollering and went to assist him. At that time, he told me to go away. I immediately told the nurse. At that time is when she received a call from [R36's] brother . Statement from DON when she went in to assist [R36] around 7:15 [p.m.]. He was upset and angry and told her to leave. She stood by the door and was finally able to work with him and remove him from the toilet . Findings . the [night shift] call light was on 44 minutes before it was turned off. Aide was attending to another resident but should have communicated by asking for help.</p> <p>R20</p> <p>R20 was admitted to the facility on [DATE] and had diagnoses including bipolar disease, anxiety disorder and mild cognitive impairment of uncertain or unknown etiology. A review of R20's MDS assessment, dated 4/2/2024, revealed R20 scored seven out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating she had severe cognitive impairment. Further review of R20's MDS assessment revealed she required substantial/maximal assistance for toilet transfer and was dependent upon staff for toilet hygiene.</p> <p>An observation on 5/14/2024 at 11:13 a.m., revealed CNA I transferred R20 from her bed to the bathroom using a sit-to-stand mechanical lift. Upon positioning R20 in front of the toilet, CNA I pulled R20's pants down past her knees and loosened the Resident's brief and lowering it down toward her knees exposing her buttocks and pubic area. CNA I made no attempt to close the bathroom door and left the Resident sitting on the toilet within sight of R20's roommate who was seated in a wheelchair on the side of the room opposite from R20. When R20 was finished urinating, CNA I lifted the Resident to standing position and with the Resident standing, proceeded to cleanse R20's genital area with the door open and R20 within direct sight of her roommate.</p> <p>R39</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R39 was admitted to the facility on [DATE] and had diagnoses including macular degeneration (limited field of vision), urinary retention, urinary tract infection and generalized muscle weakness. A review of R39's MDS assessment, dated 3/19/2024, revealed R39 scored 11 out of 15 on the BIMS assessment, indicating he had moderate cognitive impairment. Further review of R39's MDS assessment revealed he was dependent on staff for toileting, lower body dressing, sit to stand transfers, and chair/bed-to-chair transfers.</p> <p>An observation of care provided by CNA L on 5/14/2024 at 11:21 a.m. revealed R39 lying in bed wearing a white, long-sleeved shirt, yellow socks, and a blue incontinence brief. R39 was not wearing any pants and was not covered with a sheet or blanket. CNA L was observed loosening R39's incontinence brief to check the Resident for cleanliness. Further observation revealed CNA L walk away from R39's bedside to go to the Resident's bathroom to perform hand hygiene, leaving R39 lying with his brief open and not covered with a sheet or blanket. R39 was heard stating I'm cold and this is uncomfortable. During this observation R39's room was noted to be at ground level and the window blinds were left open during care for R39. An observation of the courtyard outside R39's window revealed three unidentified residents in the courtyard, one of which was in a wheelchair on the sidewalk directly outside R39's room. After performing hand hygiene, CNA L returned to fasten R39's brief, placed a pair of pants on R39 up to his med-thighs and positioned R39 sitting on the right side of his bed, facing the window. CNA L then fastened a lift sling around the Resident and proceeded to lift R39 to standing position using a sit-to-stand mechanical lift. R39 was observed to be standing directly in front of the window with the blinds open with his pants at his knees with his incontinence brief exposed. CNA L then pulled R39's pants to his waist and seated him in a wheelchair next to the bed. CNA L made no attempt to close the blinds during R39's care.</p> <p>During the interview on 5/15/2024 at 1:46 p.m., the DON reported all resident should be provided a dignified care experience, regardless of cognitive status. The DON stated ensuring dignity included covering residents exposed body part during care, closing privacy curtains and closing window blinds.</p> <p>Review of the facility policy titled Quality of Life - Dignity, last revised 2009, revealed the following, in part: Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect and individuality . Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures . Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist resident as needed by . promptly responding to the resident's request for toileting assistance .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978</p> <p>Based on observation, interview and record review, the facility failed to ensure appropriate care of an indwelling, urinary catheter for one Resident (R39) of one resident reviewed for catheter care.</p> <p>Findings include:</p> <p>R39 was admitted to the facility on [DATE] and had diagnoses including macular degeneration (limited field of vision), urinary retention, urinary tract infection and generalized muscle weakness. A review of R39's Minimum Data Set (MDS) assessment, dated 3/19/2024, revealed R39 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) assessment, indicating he had moderate cognitive impairment. Further review of R39's MDS assessment revealed he had an indwelling urinary catheter and was dependent on staff for lower body dressing (ability to dress and undress below the waist, including fasteners), toileting hygiene, sit to stand and chair/bed-to-chair transfers.</p> <p>An observation on 5/13/2024 at 11:32 a.m. revealed R39 sitting in a wheelchair on the right side of his bed. Further observation revealed urinary catheter tubing leading from R39's left pant leg to a dependent drainage bag resting on his lap, above the level of his bladder. Certified Nurse Aide (CNA) K, who was present at the time of the observation, reported she placed the bag on R39's lap after transferring him from the bed to the wheelchair. CNA K then took the dependent drainage bag and hooked it underneath the Resident's wheelchair seat. Upon further observation, the bottom of the catheter bag and tubing leading from the bag to the resident was resting directly on the floor. It was noted the dependent drainage bag was covered with a dark blue cover on two side of the bag, but the bottom was left open, exposing the bag to the floor surface. CNA K then proceeded to move R39 to the bathroom by pushing the wheelchair with the exposed bottom of the drainage bag and tubing dragging along the floor under the Resident's wheelchair.</p> <p>An observation of morning care on 5/14/2024 at 9:15 a.m. revealed R39 seated in a wheelchair on the right side of his bed with catheter tubing leading from his left pant leg to a dependent drainage bag hooked onto the left armrest of the wheelchair, above the level of R39's bladder. A small amount of clear, pale-yellow urine was observed in the tubing flowing back toward R39's body as CNA L was holding the drainage bag above the Resident. CNA L was observed picking up the catheter bag and holding the bag in front and above the seated resident to straighten the tubing before hooking the bag under the seat of R39's wheelchair seat. The drainage bag was observed to be covered with a dark blue cover on two sides with the bottom exposed and resting directly on the floor. CNA L left the room without repositioning the bag off the floor.</p> <p>During an interview immediately following the observation, CNA L reported she did not know a way to position R39's catheter drainage bag so the bag and tubing did not touch the floor. CNA L stated the dark blue cover only protected the sides of the bag and left the bottom of the bag exposed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation with Registered Nurse (RN) B on 5/14/2024 at approximately 3:45 p.m., revealed R39 lying in bed with catheter tubing leading from under the right side of his blanket to a dependent drainage bag resting completely on the floor on the right side of the bed. The dark blue, two-sided cover was observed to be pushed up toward the hook on the top of the bag, exposing the entire bag as it rested on the floor. RN B picked up the bag, adjusted the dark blue cover so that both sides of the bag were covered but the bottom was still exposed. RN B hooked the bag to the right side of R39's bed frame and reported catheter drainage bags and tubing should never directly touch the floor due to the risk of cross contamination and infection.</p> <p>During an interview on 5/15/2024 at 1:46 p.m., the Director of Nursing (DON) reported catheter tubing and bags should always be secured and never resting directly on the floor. The DON reported R39 experienced urethral trauma due to catheter becoming dislodged when his catheter tubing became entangled with his feet while he was self-propelling in his wheelchair. The DON was unsure of the exact date of the incident and reported no accident report was completed regarding the incident.</p> <p>Review of the facility policy titled Catheter Care, Urinary, last revised September 2014, revealed the following, in part: The purpose of this procedure is to prevent catheter-associated urinary tract infections . The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . Infection Control . Be sure catheter tubing and drainage bag are kept off the floor.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330</p> <p>This citation relates to Intake #MI00142921.</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate staffing of Certified Nursing Assistants (CNAs) to provide necessary care and services for three Residents (R18, R23, and R48) of 14 sampled residents, and six confidential interviewable Residents from the group meeting facility task. This deficient practice resulted in feelings of frustration related to delay in staff responding to call lights and the potential for adverse resident outcomes.</p> <p>Findings include:</p> <p>Review of R23's Minimum Data Set (MDS) assessment, dated 3/26/24, revealed admission to the facility on [DATE], with diagnoses including osteomyelitis (bone infection), diabetes, and kidney disease. R23 was dependent for toileting, required maximal assistance for transfers, and was frequently incontinent of bladder and bowel. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R23 was cognitively intact.</p> <p>Review of R48's MDS assessment, dated 4/10/24 revealed admission to the facility on [DATE], with diagnoses including stroke and atrial fibrillation (an irregular heart rhythm). R48 was dependent for toileting and transfers, frequently urinary incontinent, and always incontinent of bowel. The BIMS assessment revealed a score of 12/15, which showed R48 had moderate cognitive impairment.</p> <p>During the initial tour on 5/13/24 at 11:23 a.m., R48 reported they waited too long for their call light to be answered every day, and they experienced incontinence. R48 reported this occurred the most when there were only two Certified Nurse Aides (CNAs) for the entire building.</p> <p>During the initial tour on 5/13/24 at 2:20 p.m., R23 reported the facility did not have enough nursing aide staff, and they appeared rushed. R23 stated there should be more staff on their hall to meet the care needs of the residents who could not speak for themselves.</p> <p>During an observation on 5/14/24 at 10:07 a.m., the nursing staff posting sheet in the lobby showed a census of 54 residents. The posting further revealed from 6:30 a.m. to 6:30 p.m., there were two Certified Nursing Aides (CNA's) scheduled, and three nurses. This showed there were only two CNA's scheduled for the entire facility with approximately 27 residents each, a 1:27 ratio.</p> <p>During the confidential group meeting on 5/14/24 at 1:31 p.m., residents collectively reported concerns regarding staff answering call lights timely and not receiving water. Specific concerns were as follows:</p> <p>One confidential Resident described the staff were overwhelmed and sometimes they had a bad attitude, as there were not enough CNAs to care for the residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Another confidential Resident described a few days ago they pushed their call light due to coughing at night and needed cough syrup, and nursing staff never came. They stated, The thing is, I am well .Someday I won't be able [to toilet themselves]. I worry about my old age, as I see what is happening around me. Someday, I won't be able to stand up .</p> <p>Another confidential Resident reported they waited 30 minutes for their call light to be answered, and sometimes they turned it off after this as nobody came to answer their call light, when they needed water on the night shift, which they stated continued to occur.</p> <p>Another confidential Resident reported they waited 40 minutes about a week ago in the bathroom as they needed help wiping themselves after toileting and no staff came to assist. They explained when this occurred [on several other occasions] they transferred back to bed and soiled their sheets, which bothered them. They stated, We got people [residents] that have dementia and they are yelling and screaming at night, and you never know if they need help, and people [residents] are getting out of bed [unsupervised when they needed assistance] . They described their neighbor (another resident) needed two person assistance for his care, and when staff were with him, there were no other aides available for 30 minutes while performing his care (when there were two CNAs on the night shift).</p> <p>Another confidential Resident reported they waited up to a half hour at night when they requested their medications. They clarified some nurses did not assist when there were only two aides in the building at night, which happened again about two days ago, and longer call wait times. They stated, My roommate had to be put on the bed pan and the nurse was standing right there .I said to her, [Roommate's name] has to go on the bedpan and she said, 'I can't you help you. I have got pills to pass.' I feel since there were only two CNAs [in the facility] she should have stepped in .At night we have sundowners [residents with dementia], and they [residents] are getting up out of their chairs [unsupervised] . They stated they believed falls were possibly occurring at night due to low staffing.</p> <p>Another confidential Resident reported they were frustrated as some CNAs had an attitude when someone called off work with little notice, and they heard them talking about it.</p> <p>Review of the resident council meeting minutes showed the following:</p> <p>May 2024: Three residents reported their call lights were not being answered timely, and one said sometimes it was not.</p> <p>April 2024: Two residents reported their call lights were not being answered timely and two said sometimes it was not.</p> <p>March 2024: One resident reported their call light was not answered timely and four residents stated sometimes it was not.</p> <p>February 2024: Four residents reported their call lights were not answered timely.</p> <p>Review of 4/4 of the resident council meeting minutes showed old business included notations of residents reporting their call lights were not answered timely.</p> <p>Further review of the April 2024 meeting minutes revealed residents (unspecified - 9 in attendance) stated that they were not consistently getting a water pass at night.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/14/24 at 3:48 p.m., Activity Director (Staff N) was asked about call wait times and water pass concern reported by residents. Staff N confirmed residents in the resident council meeting collectively reported extended call wait times of 20 to 45 minutes in the past few months, including this month (May 2024). Staff N reported they shared their concerns with the Director of Nursing (DON) when this was reported, and provided this Surveyor with one Resident Council response form, dated 4/30/24.</p> <p>Review of the Resident Council Department Response Form, dated 4/3/24, signed by the DON on 4/4/24, revealed, 1. Residents stated they are not consistently getting a water pass at night. 2. Four of nine residents are waiting 1/2 hour on their call lights. Mostly at night but sometimes in the day. The DON response was, Will speak with CNA and nurse on NOC [night shift] to ensure water pass is done every night and as well as call light response time.</p> <p>During an interview on 5/15/24 at 9:35 a.m., CNA R confirmed there were only two nursing aides on shift the night prior (5/14/24) for much of the shift.</p> <p>Review of staff postings for the past two weeks (from 4/30/24 through 5/12/24) received from Staff G showed low nursing aide staffing (two aides) on the night shift from 6:30 p.m. to 6:30 a.m. as follows:</p> <p>4/30/24: Census: 55. Two CNA's. Three nurses. No call ins.</p> <p>5/10/24: Census: 55. Two CNA's. Three nurses. No call ins.</p> <p>Review of call light logs for the prior two weeks (from 5/01/24 to 5/14/24) for resident council group meeting residents revealed two residents/rooms with extended call wait times.</p> <p>Call light wait times of over 20 minutes were noted below:</p> <p>One confidential Resident's bathroom call light activated:</p> <p>5/04/24 at 10:27 a.m : Elapsed time to room: 22:28 (22 minutes and 28 seconds).</p> <p>5/05/24 at 8:43 p.m :Elapsed time to room: 38:19.</p> <p>5/05/24 at 6:10 a.m.: Elapsed time to room: 22:35.</p> <p>Another confidential Resident's bed call light activated:</p> <p>5/02/24 at 12:11 a.m.: Elapsed time to room. 37:36.</p> <p>5/02/24 at 5:41 a.m.: Elapsed time to room. 45:40.</p> <p>5/03/24 at 4:01 p.m.: Elapsed time to room. 30:49.</p> <p>5/04/24 at 2:02 a.m.: Elapsed time to room: 32:28.</p> <p>5/04/24 at 2:43 p.m.: Elapsed time to room: 36:00.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5/04/24 at 7:53 p.m.: Elapsed time to room: 40:44.</p> <p>5/05/24 at 8:00 a.m.: Elapsed time to room: 32:31.</p> <p>5/10/24 at 7:11 p.m.: Elapsed time to room: 24:04.</p> <p>5/13/24 at 8:14 p.m.: Elapsed time to room: 34:01.</p> <p>In summary, the call light logs showed nine times (during a two week period) when call light wait times were verified in excess of 30 minutes for two residents/rooms.</p> <p>Review of the staff postings received on 5/15/24 from Staff G showed low staffing on the night shift as follows:</p> <p>5/13/24: Census: 55. Two CNA's. Three nurses. One call in (CNA).</p> <p>5/14/24: Census: 54. Two CNA's. Three nurses. One call in (CNA).</p> <p>It was noted on 5/14/24, a third CNA arrived at 11:00 p.m. to finish working on the night shift. It was later confirmed by the DON on 5/13/24 there were two CNAs on the night shift, and on 5/14/24 there were two CNAs on part of the night shift.</p> <p>During a phone interview on 5/15/24 at 3:29 p.m., CNA P was asked about staffing on the night shift. CNA P confirmed there were only two aides on the night shift on 5/10/24, two nurses, and another nurse, Licensed Practical Nurse (LPN) A, who helped with the medication pass. CNA P reported they regularly worked the night shift, and it bothered them when the staffing was low, because residents waited a long time sometimes for staff to answer their call lights. CNA P stated at times this was 30 minutes or longer when they were shorter staffed, especially with only two CNAs. CNA P explained it was difficult to answer resident alarms when sounding because they were providing care for another resident. CNA P reported while they changed their residents' clothes and briefs, they had found other residents put to bed by other staff in their clothes (no gown) and had observed them wearing the same clothes two days later. CNA P reported there were some residents who would take 30 minutes for their care, which made it difficult to answer another resident's call light. CNA P reported this bothered several of the facility residents, who reported feelings of frustration waiting for extended call light wait times. When asked about any outcomes, CNA P reported sometimes they found residents left wet who had not been changed timely, both on the night and day shift. CNA P clarified some of the nurses assisted the CNAs on the night shift with resident cares however there was one nurse who refused to assist them. CNA P reported some residents were not being repositioned appropriately by other staff, as they found some residents in the same position. They could not confirm or deny staff shortages caused falls or skin concerns but felt this placed residents at risk for both.</p> <p>During an interview on 5/15/24 at 3:52 p.m., LPN A reviewed the nursing schedule with this Surveyor, and confirmed they worked on 5/10/24 when there were two aides on the night shift. LPN A reported they could use more CNAs and declined to comment further when asked about the 1:28 CNA to resident ratio with two aides working at night.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/15/24 at 4:33 p.m., the Nursing Home Administrator, NHA H and the DON were asked about facility CNA staffing, per the facility assessment. Neither was able to clearly interpret the numbers of CNA staff required, whether it was actual nurse aides, full time equivalents, hours, or other. The DON was asked how they staffed, which was reported by both number of residents and resident acuity. The DON explained with a census of 61 and higher, they would staff at least 3 CNAs at night. Concerns were reviewed respective to resident council meeting minutes, the group meeting interview, staff posting sheets, call light logs, staff interviews, and reported resident outcomes. NHA H conveyed they understood the concerns, and they had no additional comment other than to say they had newly hired staff incoming. The DON acknowledged staffing deficits and stated on the night shift if no one picked up a shift then there were sometimes two aides and three nurses at night, which was not ideal. The DON acknowledged the concern and confirmed the three night shift nurses were assigned as nurses and not CNA's when they worked at night, although they were expected to assist the CNAs with resident cares.</p> <p>Review of the facility assessment, dated 1/01/24, revised 1/23/24, revealed the average daily facility resident census was 64. The facility resources section, Page 7, revealed, Part 3. Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies . Page 8 revealed, Describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time. Consider if and how the degree of fluctuation in the census and acuity levels impact staffing needs. This page showed a column labeled Staff and showed Direct Care Staff [CNAs]. The adjacent column showed Plan: Days - 6 aides @ 12-hour shifts. Evenings [Night shift]: 4 aides @ 12-hour shifts. Given the census of 64 residents, it was noted with 4 CNAs, the CNA to resident ratio was 1:16, reflecting one CNA for 16 residents, per the facility assessment. When there were only two CNAs on the night shift, which was discovered during April 30th and May 15th (2024), the CNA to resident ratio was 1:27 or 1:28, given a census of 54 or 55 residents, respectively. This placed a significantly high resident care expectation on the two evening (night) shift CNAs. When there were three CNAs on the evening (night) shift, this ratio decreased to 1:18, which was still higher than the 1:16 facility assessment expectation. The facility assessment represented facility population acuity by revealing 45 residents required one to two person assistance, and eight were dependent for transfers, given an average census of 64 residents. The assessment confirmed resident and staff interviews which revealed there were residents who required two-person assistance and/or a mechanical lift for transfers in the facility due to dependence.</p> <p>Review of the policy Staffing, revised April 2007, revealed, 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan .</p> <p>40383</p> <p>Resident 18 (R18)</p> <p>R18 was admitted on [DATE] with a primary diagnosis of traumatic brain dysfunction. Review of R18's MDS assessment, dated 2/12/24 revealed R18 was dependent on staff for toileting, dressing, and personal hygiene. The BIMS assessment revealed a score of 9 out of 15 indicating moderate cognitive impairment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the initial tour on 5/13/24 at 10:49 AM, R18 stated he had many staffing concerns. He stated there were some staff who did not seem to care and there were not enough staff. He often had to wait.</p> <p>On 5/15/24 at 2:17 PM, the call light in the hallway above R18's room was observed to be on. Upon entering the room this surveyor asked R18 if his call light was answered timely when he pushed it. R18 responded, I wish. He said he pushed his call light a while ago and he was still waiting. Every day I have to wait. The call light in the hall above R18's door continued to be on. A nurse was right outside the door standing at her med cart, but she did not look up or inquire what R18 needed. This surveyor then re-entered the room and asked R18 if he had to wait often. He stated, My job is to wait.</p> <p>The call light logs for the prior two weeks for R18 were requested and revealed the following examples of wait times exceeding 20 minutes:</p> <p>5/1/24 at 8:04 AM elapsed time to room [ROOM NUMBER]:46 (24 minutes 46 seconds)</p> <p>5/1/24 at 11:52 AM elapsed time to room [ROOM NUMBER]:42</p> <p>5/1/24 at 1:57 PM elapsed time to room [ROOM NUMBER]:43</p> <p>5/1/24 at 7:56 PM elapsed time to room [ROOM NUMBER]:52:10 (1 hour 52 minutes 10 seconds)</p> <p>5/1/24 at 10:44 PM elapsed time to room [ROOM NUMBER]:23</p> <p>5/2/24 at 4:55 AM elapsed time to room [ROOM NUMBER]:37:50</p> <p>5/2/24 at 7:11 PM elapsed time to room [ROOM NUMBER]:12</p> <p>5/2/24 at 9:56 PM elapsed time to room [ROOM NUMBER]:41</p> <p>5/3/24 at 3:39 AM elapsed time to room [ROOM NUMBER]:41</p> <p>5/3/24 at 12:55 PM elapsed time to room [ROOM NUMBER]:13</p> <p>5/3/24 at 2:01 PM elapsed time to room [ROOM NUMBER]:39</p> <p>5/3/24 at 7:52 PM elapsed time to room [ROOM NUMBER]:09</p> <p>5/3/24 at 9:01PM elapsed time to room [ROOM NUMBER]:27</p> <p>5/4/24 at 6:03 PM elapsed time to room [ROOM NUMBER]:42</p> <p>5/4/24 at 6:45 PM elapsed time to room [ROOM NUMBER]:11</p> <p>5/5/24 at 9:00 AM elapsed time to room [ROOM NUMBER]:33</p> <p>5/5/24 at 8:08 PM elapsed time to room [ROOM NUMBER]:41</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5/6/24 at 3:56 AM elapsed time to room [ROOM NUMBER]:52</p> <p>5/6/24 at 10:39 AM elapsed time to room [ROOM NUMBER]:45</p> <p>5/6/24 at 1:13 PM elapsed time to room [ROOM NUMBER]:34</p> <p>5/6/24 at 4:39 PM elapsed time to room [ROOM NUMBER]:57</p> <p>5/6/24 at 5:52 PM elapsed time to room [ROOM NUMBER]:40</p> <p>5/6/24 at 8:44 PM elapsed time to room [ROOM NUMBER]:36</p> <p>5/7/24 at 7:02 PM elapsed time to room [ROOM NUMBER]:34</p> <p>5/7/24 at 8:21 PM elapsed time to room [ROOM NUMBER]:09:06</p> <p>5/8/24 at 12:45 AM elapsed time to room [ROOM NUMBER]:05:58</p> <p>5/8/24 at 3:05 AM elapsed time to room [ROOM NUMBER]:07</p> <p>5/8/24 at 5:45 AM elapsed time to room [ROOM NUMBER]:30</p> <p>5/8/24 at 6:53 PM elapsed time to room [ROOM NUMBER]:29</p> <p>5/8/24 at 10:00 PM elapsed time to room [ROOM NUMBER]:01</p> <p>5/9/24 at 10:41 AM elapsed time to room [ROOM NUMBER]:34</p> <p>5/10/24 at 7:10 AM elapsed time to room [ROOM NUMBER]:32</p> <p>5/10/24 at 10:32 AM elapsed time to room [ROOM NUMBER]:32</p> <p>5/10/24 at 1:52 PM elapsed time to room [ROOM NUMBER]:45</p> <p>5/10/24 at 4:06 PM elapsed time to room [ROOM NUMBER]:44</p> <p>5/10/24 at 6:35 PM elapsed time to room [ROOM NUMBER]:47</p> <p>5/11/24 at 1:55 AM elapsed time to room [ROOM NUMBER]:54</p> <p>5/11/24 at 5:13 AM elapsed time to room [ROOM NUMBER]:06</p> <p>5/11/24 at 6:09 PM elapsed time to room [ROOM NUMBER]:22</p> <p>5/11/24 at 8:40 PM elapsed time to room [ROOM NUMBER]:35:11</p> <p>5/12/24 at 12:03 AM elapsed time to room [ROOM NUMBER]:29:53</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Boulder Park Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 14676 W Upright Charlevoix, MI 49720	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5/12/24 at 4:44 AM elapsed time to room [ROOM NUMBER]:05:30</p> <p>5/12/24 at 6:16 AM elapsed time to room [ROOM NUMBER]:36</p> <p>5/12/24 at 7:07 AM elapsed time to room [ROOM NUMBER]:54</p> <p>5/12/24 at 8:31 PM elapsed time to room [ROOM NUMBER]:12</p> <p>5/12/24 at 9:22 PM elapsed time to room [ROOM NUMBER]:45:35</p> <p>5/13/24 at 6:23 AM elapsed time to room [ROOM NUMBER]:20</p> <p>5/13/24 at 7:09 PM elapsed time to room [ROOM NUMBER]:07:40</p> <p>5/13/24 at 8:20 PM elapsed time to room [ROOM NUMBER]:38:31</p> <p>In summary, the call light logs from 5/1/2024 to 5/13/2024 recorded R18 had to wait more than 20 minutes to get help when using his call light 49 times. Further, this report showed R18 waited more than an hour 10 times during these 13 days.</p>		