

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/15/2024
NAME OF PROVIDER OR SUPPLIER  Ashley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  103 West Wallace Street Ashley, MI 48806	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure call lights and fluids were within reach for 2 residents (Resident #49 and Resident #12) out of 3 resident reviewed for accommodation of needs.</p> <p>Findings:</p> <p>Resident #49 (R49)</p> <p>Review of a face sheet revealed R49 was a [AGE] year-old-male, admitted to the facility on [DATE] with pertinent diagnoses of dementia, seizure disorder, and protein-calorie malnutrition. Review of a Brief Interview for Mental Status (BIMS) dated 11-16-23 revealed R49 had severe cognitive impairment.</p> <p>During an observation on 02/12/24 at 10:00 AM, R49 laid resting in bed, the call light was looped over the bed frame and down between the metal slates of the frame; out of sight and out of reach of the resident. The over bed table with a cup of fluids sat near the room dividing curtain and out of reach of the resident.</p> <p>During an observation on 02/12/24 at 12:01 PM, R49 laid resting in bed with eyes closed and the call light and cup of fluids remained out of reach of the resident.</p> <p>During an observation on 02/12/24 at 3:51 PM, R49 laid resting in bed with eyes closed and the call light and cup of fluids remained out of reach of the resident.</p> <p>During an observation on 02/13/24 at 8:06 AM, R49 laid in bed resting with eyes closed and the call light was looped over the bed frame and out of reach and out of sight of the resident.</p> <p>During an observation on 02/13/24 at 2:38 PM, the resident laid in bed resting and the call light remained looped over the bed frame toward the inside of the bed, out of sight and out of reach of R49.</p> <p>During an observation on 02/14/24 at 8:12 AM, R49 laid in bed resting with eyes closed and the call light remained out of sight and out of reach, looped under the bed frame. No fluids for hydration were located in R49's side of the room.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a Care Plan for R49 reflected the following interventions: encourage adequate fluid intake, and keep frequently used items such as a water, tv remote, call light etc within reach.</p> <p>Resident # 12 (R12)</p> <p>Review of a face sheet revealed R12 was a [AGE] year-old-male, admitted to the facility on [DATE], with pertinent diagnoses of dementia, history of falls, and paralysis on the left side of the body.</p> <p>During an observation on 02/12/24 at 10:04 AM, R12 laid resting in bed and the call light touch pad sat in the 2nd drawer of a 3 drawer plastic tower next to the residents bed, out of sight and out of reach.</p> <p>During an observation on 02/13/24 at 2:35 PM, R12 rested in bed and the call light touch pad sat in the 2nd drawer of a plastic 3 drawer tower next to the bed, out of sight and out of reach of the resident. R12 was asked to show the surveyor where the call light was and he could not.</p> <p>Review of a Care Plan for R12 revealed the following interventions: staff to encourage me to use my call light to get assistance to transfer and ambulate, and I frequently have my call light on the floor per my preference. Please ensure that I can reach it if it is on the floor.</p> <p>During an interview on 02/12/24 at 11:08 AM, certified nurse aide (CNA) C stated that the expectation for staff regarding call lights was to ensure that call lights are within reach of the residents each time staff go into a room.</p> <p>Review of a facility policy: Call Lights-Accessibility and Timely Response, last reviewed 11/01/22, reflected . The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing to all residents to call for assistance .Staff will ensure the call light is within reach of the resident.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31197</p> <p>This citation pertains to Intake Number(s): MI00139878, MI00139961, MI00141377, MI00142340.</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse timely to the state agency and law enforcement for 6 of 6 residents, Resident #25, #35, #43, #52, #106, and #109 (R25, R35, R43, R52, R106 and R109) reviewed for timely reporting. This deficient practice resulted in allegations of abuse with injury and serious injury to go unreported to local law enforcement and uninvestigated.</p> <p>Findings include:</p> <p>The facility provided a copy of the Abuse, Neglect and Exploitation dated 11/1/2022 for review. The policy reflected, IV. Identification of Abuse, Neglect, and Exploitation .1. Resident, staff, or family report of abuse .3. Physical injury of a resident, of unknown source .VII. Reporting/Response .1. Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the a allegation do not involve abuse and do not result in serious bodily injury .</p> <p>R106</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R106 admitted to the facility on [DATE], with diagnosis of heart disease, high blood pressure, weakness and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 5 out of 15 which represented R106 had severe cognitive impairment. R106 required the assistance of 1-2 staff members with all activities of daily living.</p> <p>The progress notes reflected on 9/22/23 R106 complained of severe arm pain and refused to have her sweatshirt removed. The family and physician were notified and at 6:52 PM was transported to the emergency room for further evaluation and treatment.</p> <p>The progress notes on 9/22/23 at 10:47 PM reflected that the emergency room nurse called the facility and made the staff aware of R106's new diagnosis of a fracture to the right humerus (upper arm).</p> <p>The facility provided a copy of the MIFRI (Michigan Facility Reportable Incident) Incident Submission Confirmation email dated 9/25/23 at 4:49 PM for review. The email reflected that the facility reported the serious injury of unknown origin to the state agency 3 days after the injury was discovered and not within 2 hours as the facility policy reflects.</p> <p>The facility provided a copy of the Incident Summary that was submitted to the state agency dated 10/2/23 for review. The report reflected, Was Law Enforcement Contacted: No. The report was signed by the Nursing Home Administrator (NHA).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/14/24 at 9:30 AM, when asked if the unobserved/unexplained serious bodily injury (arm fracture) was reported to the state agency on 9/25/23, (3 days after the facility became aware of the fracture), the NHA stated it was reported on 9/25/23 but could not recall why it was submitted late. When asked if the police were notified, the NHA stated, No because her fracture was due to osteoporosis (reduced bone mass) and it wasn't suspicious. According to the facility policy all allegations of serious injury will be reported to the state agency and to local law enforcement within 2 hours.</p> <p>During a subsequent interview on 2/15/24 at approximately 1:00 PM, when asked who decides if an incident is suspicious of a crime, the NHA did not respond. When the surveyor stated, The police? the NHA stated, Yes.</p> <p>37872</p> <p>R25</p> <p>Review of R25's Face Sheet dated 2/14/24 revealed resident was originally admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease, Bipolar disorder, Pain disorder with related psychological factors, Anxiety disorder due to known physiological condition, atrial fibrillation, hypertension, Heart failure, Type 2 diabetes mellitus and Schizoaffective disorder.</p> <p>Review of R25's progress note dated 9/27/23 at 8:17 AM, revealed SW (Social Work) was notified that the resident made contact with another resident in the face open handed. Resident was irritated that the other resident was trying to hug her prior incident.</p> <p>The facility provided a copy of the Incident Summary that was submitted to the state agency dated 10/4/23 for review. The report reflected, Was Law Enforcement Contacted: No. The report was signed by the Nursing Home Administrator (NHA).</p> <p>Reviews R25's progress notes for 11/27/23 at 2:38 PM revealed, Resident was sitting in the dining room, two other residents were yelling at each other, staff has stepped in between them, resident gets up and walks behind one of the other residents and hits her in the back, the other resident turned around and raised her arms as to hit her back, was not observed if contact was made before staff intervened, res denied getting hit, one asked why she had hit the other resident she stated. it was for yesterday, she know what she did. Resident would not say anything more and walked away to room, resident would not let staff assess, her face did not have any concerns, no s/sx of pain or discomfort noted, administer notified immediately, message left with guardian and physician notified of incident. Staff educated on redirecting residents away from each other as tolerated.</p> <p>The facility provided a copy of the Incident Summary that was submitted to the state agency dated 12/4/23 for review. The report reflected, Was Law Enforcement Contacted: No. The report was signed by the Nursing Home Administrator (NHA).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/14/24 at 2:15 PM, NHA was asked if she reported the FRI's to Law enforcement. NHA stated, I do not report if there were no injuries or if only 1st aide was required. I would not call the police unless it was more than 1st aide. NHA stated she does not report if the residents were not in-distress from the incident. NHA further revealed, we do not have an agreement with the police on what constitutes more than a crime and that needs to be reported. Will report if it is serious crime, willful intent/injury that requires more than 1st aide.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31197</p> <p>This citation pertains to Intake Number(s): MI00139878</p> <p>Based on interview, and record review the facility failed to follow the facility to thoroughly investigation abuse for 1 of 6 residents, Resident #106, (R106) reviewed for abuse.</p> <p>Findings include:</p> <p>The facility provided a copy of the Incidents and Accidents policy dated 11/1/2022 for review. The policy reflected, The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent reoccurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences .5. The following incidents/accidents require an incident/accident report but are not limited to .Alleged abuse . Combative behavior .Resident to resident altercations . Unobserved injuries .</p> <p>The facility provided a copy of the Abuse, Neglect and Exploitation dated 11/1/2022 for review. The policy reflected, IV. Identification of Abuse, Neglect, and Exploitation .1. Resident, staff, or family report of abuse .3. Physical injury of a resident, of unknown source .VII. Reporting/Response .1. Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the a allegation do not involve abuse and do not result in serious bodily injury .</p> <p>R106</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R106 admitted to the facility on [DATE], with diagnosis of heart disease, high blood pressure, weakness and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R106 had severe cognitive impairment. R106 required the assistances of 1-2 staff members with all activities of daily living.</p> <p>This surveyor requested to review all incident and accident reports for R106 from 9/1/23 until 11/25/23 on 2/12/23 at 10:40 AM and a second request was made on 9/14/23 at 9:10 AM. The Nursing Home Administrator (NHA) stated there was no incident report for the investigation of the fractured arm. According to the facility policy an incident is required for all unobserved injuries and allegations of abuse.</p> <p>The progress notes reflected the following:</p> <p>-9/22/23 at 4:59 PM, Resident complained of pain to the right arm and shoulder. Refused to have her sweatshirt removed and refused to allow staff to touch or move her arm, her family were at bedside, Tylenol was given, and the physician ordered x-rays.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-9/22/23 at 6:52 PM, Resident was sent to the emergency room via EMS, accompanied by her family.</p> <p>-9/22/23 at 10:47 PM, the emergency room called and reported that R106 was diagnosed with a right arm fracture.</p> <p>-9/23/23 at 12:21 AM, R106 returned to the facility wearing a sling to the right arm.</p> <p>According to the facility's investigation submitted to the state agency on 10/2/23, R106's roommate alleged that CNA A broke R106's arm while transferring her in a sit to stand lift. The report reflected, Residents on the unit were interviewed if able if any staff have hurt them or have had any problems with staff and skin assessments completed on those not able to be interviewed .(Name of CNA A) the nurse aide was interviewed regarding the transferring (Name of R106) the day of the incident. She stated that they used the sit to stand as noted and when (Name of R106) stands it stretches her legs and she does complain of pain regarding her legs at times and she did that day, but not in regards to her arm .</p> <p>During an interview on 2/13/24 at 10:35 AM, CNA A stated she did not work on 9/22/23 but she had worked the day before on 9/21/23 and recalled giving a statement about the sit to stand transfer. When asked if R106 complained of pain during the transfer, CNA A stated, No.</p> <p>The facility provided copies of the actual schedule worked with sign-in sheets for 9/21/23 and 9/22/23. The schedule reflected that CNA A worked 6:00 AM until 6:00 PM (day shift) on 9/21/23 and did not work on 9/22/23 (the day R106's injury was first noted).</p> <p>During an interview on 2/14/24 at 9:10 AM, the Nursing Home Administrator (NHA) stated she completed the investigation for R106's arm fracture. When asked for the list of Residents that were verbally interviewed regarding the allegation of abuse and rough treatment and a list of those who received skin assessments, the NHA stated she did not have a list. There was no evidence that any residents were interviewed or assessed regarding the abuse allegation. When asked if any of the care givers who provided direct care to R106 on 9/22/23 including using the sit to stand lift that day were interviewed, the NHA stated, No. The NHA stated that the facility concluded that the sit to stand lift sling likely contributed to the arm fracture so R106 was changed to a hoyer (full body) lift. When asked if observations of the sit to stand lift and sling were done to ensure proper training and technique were used and no equipment malfunction was noted, the NHA stated, No.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>31771</p> <p>Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist was present to properly assess, implement, and manage the Infection Prevention and Control Plan during a COVID 19 outbreak.</p> <p>Findings:</p> <p>During the Infection Control review the facility provided the Infection Preventionist (IP) certificate that the Director of Nursing (DON) had attained on 2/21/2023. The facility also provided for review the IP certificate for the Nursing Home Administrator (NHA). However, the NHA did not provide documentation of the qualifying criteria for an IP.</p> <p>In an email response to a request for professional qualifications for an IP the NHA acknowledged that she did not meet the regulatory requirements of an IP.</p> <p>On 2/15/23 at 1:22 PM the Director of Human Resources (DHR) E reported that the DON was on leave from 10/7/23 through 12/13/23.</p> <p>During an interview conducted 2/15/24 at 2:15 PM the DON reported Registered Nurse (RN) S assumed the clinical duties of the IP while she was on leave. The DON reported that RN S is not certified as an IP. The DON indicated she provides the Infection Control report to regular Quality Assurance meetings but does not know who provided this report during her absence. The DON acknowledged that there was a COVID 19 outbreak during her absence, but that RN S covered the Clinical portion and the NHA handled the paperwork.</p> <p>In a follow up interview conducted 2/15/24 at 2:41 PM, the DON reported that a certified regional IP was available for guidance to RN S during the COVID 19 outbreak. Following a request for a record of QA meeting attendees during her leave of absence the DON reported that the Regional IP did not attend the facility QA meetings.</p> <p>Review of the Electronic Medical Record (EMR) Progress Notes reflected documentation that three Residents had tested positive for Covid 19 from 11/13/23 to 11/22/23 (Resident #35 (R35) on 11/13/23, R157 on 11/17/23 and R30 on 11/22/23).</p> <p>Postings provided by the facility titled Covid 19 Notification were reviewed. The first of three postings reflected the current guidance would be followed for ten days (11/13/23 to 11/23/23). The second and third postings reflected the guidance would be followed for fourteen days (11/17/23 to 12/1/23 and 11/21/23 to 12/6/23, respectively) .</p> <p>The documents provided by the facility titled, Covid 19 Exposure Checklist -Resident/Employee Contact Tracing were reviewed. The review reflected a Checklist had been completed for each of the above Covid 19 positive Residents. The signature section of each document titled INFECTION PREVENTIONIST/DON/DESIGNEE VERIFYING COMPLETION OF THE TASKS ON THIS CHECKLIST were unsigned and undated. However, the boxes next to the individual tasks reflected the initials of the NHA.</p>		