| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235543 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lincoln Haven Nursing and Rehabilitation Community | 950 Barlow Rd<br>Lincoln, MI 48742 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330<br><br>This citation relates to Intake #Mi00144666 and #MI00144651.<br><br>Based on observation, interview, and record review, the facility failed to provide four Residents (R1, R2, R4, and R7) of 12 residents reviewed for food preferences and alternate meal options, who were reviewed for food concerns. Findings include:<br><br>Some identifiers have been changed to Staff, as some of the interviewees requested confidentiality.<br><br>R2<br><br>Review of R2's Minimum Data Set (MDS) assessment, dated 5/01/24, revealed R2 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease and depression. The assessment revealed R2 required set up with eating and moderate assistance with transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R2 was cognitively intact.<br><br>During an observation on 6/03/24 at 12:10 p.m., R2 was observed eating in the facility dining room, seated in a manual wheelchair. R2's was observed feeding herself mashed potatoes and wax beans from her plate. R2 was asked about her lunch meal. R2 stated, The mashed potatoes and gravy is ok. It's all I had. I didn't want the fish .The only food they had today was fish and ravioli, so I didn't get a sandwich ;. I asked for something else. I don't like that either [ravioli]. I'm done. I'm a little hungry.<br><br>On 6/03/24 at 12:20 p.m., Surveyor confirmed with the facility kitchen staff fish and ravioli were the only entrees available for the lunch meal. R2 reported she was offered snacks in the evening when she did not like the entree, but this was not acceptable to her, as she wanted meal alternatives, which were not always available. R2 described further how she never received fresh fruit, and liked oranges, apples, and grapes. R2 added, I have lost some weight. One day, I got a sandwich in a bag, fried bologna, and I just left it [did not eat the meal] .It was a few weeks ago, when they had no cook here. I went hungry .<br><br>R4<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R4's MDS admission assessment, dated 4/15/24, revealed R4 was admitted to the facility on [DATE], with diagnoses including kidney disease, diabetes, malnutrition, and depression. The assessment revealed R4 required set-up for eating and moderate assistance for transfers. The BIMS assessment revealed a score of 15/15, which showed R4 was cognitively intact.<br><br>During an interview on 6/3/24 at 12:30 p.m. R4 reported, The food should be a better quality, and explained, The salisbury steak meal is not real meat; it is like a TV dinner. R4 reported she sometimes missed meals, as she was not given another option if she did not like the meal. R4 described she did not like the sausage or ham, and stated, I don't eat the ham as it is really thick and I can't eat it. R4 reported one egg and a piece of toast was not an adequate breakfast, stating, I would like two eggs. When asked if they received any alternative meal selections, R4 reported, I am never given another option. Sometimes I don't eat . R4 reported she was frustrated with the food quality and lack of alternate choices offered, and said she was hungry sometimes.<br><br>During an interview with the Nursing Home Administrator (NHA) on 6/4/24 at approximately 4:10 p.m., it was confirmed there were days residents received one egg and toast, as the egg served as a protein, and only 1 ounce was required to be served for breakfast, or an omelet, which was larger and had about 2 oz of protein.<br><br>During an observation on 6/4/24 at approximately 4:30 p.m., Surveyor asked to see the portion size for a one ounce serving of eggs, with the NHA and Staff B. The NHA showed Surveyor a two-ounce ice cream style scoop and said this was typically the amount provided to residents. Staff B showed Surveyor a smaller scoop, 1/2 the size of the first scoop, which was one ounce, which they reported they sometimes used to serve the egg portion for each resident. It appeared to be a small serving size for an egg entree. Staff B was asked if they believed this would be an adequate serving size for the average resident. Staff B stated, It would not be enough for me .<br><br>During a phone interview on 6/4/24 at 3:50 p.m., Staff G reported R4 had requested healthier food choices for the meals, and reported R4 did not like the meals at the facility, and there was nothing extra available.<br><br>During an interview on 6/4/24 at approximately 2:30 p.m., Registered Dietician (RD) L was asked about kitchen staff providing 1 oz of eggs (small scoop) at some meals, and if this was considered an adequate portion of eggs. RD L reported the small scoop was equivalent to 1 oz, and there was no requirement for the facility to provide 2 oz or 2 eggs to facility residents.<br><br>R1<br><br>A confidential complaint was received by the State Agency on 5/22/24, which noted R1 was not receiving an appropriate diet for her low salt needs, given her cardiac diagnosis. The complainant also reported R1 received a fried bologna sandwich and cream of mushroom soup for dinner during the past week, with no alternate offered, and was told, Everyone gets the same thing. The complainant noted there was no fresh fruit served, and kool-aide was served at meals as the beverage. The complaint alleged R1 did not receive dinner on 5/13/24, Mother's Day, and the food and drinks were not palatable.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R1's MDS assessment, dated 4/5/24, revealed R1 was admitted to the facility on [DATE], with diagnoses including heart failure, diabetes, malnutrition, and depression. The assessment revealed R1 required set-up with eating and was dependent for transfers. The BIMS assessment revealed R1 scored 15/15, which showed R1 was cognitively intact.<br><br>During an interview on 6/3/24 at approximately 5:10 p.m., R1 was asked about their meals. It was observed R1 was wearing oxygen, a gown, and was in a bariatric bed. R1 stated, There is a lot of salt. I just don't like salt. I have two leaky heart valves. I did have swelling and it has gone down. Some of the food is horrible. Their chicken and dumpling soup .I wouldn't know what it is by looking at it . R1's dinner meal arrived during the interview. The meal was a ham sandwich, with a fruity appearing red watered-down drink, which R1 reported tasted good as it was cherry flavored. A banana was served with the meal. R1 stated she would have wanted soup with the meal, and stated, I don't remember if it was offered, and stated she does not like cream of mushroom soup but would take an alternate soup. R1 looked at her tray, and stated, Where is my dessert? Surveyor saw an unnamed staff member in the hall and asked about dessert. The aide reported the banana was the dessert. It was noted R1's tray card stated, NAS [no added salt] and a regular diet.<br><br>During a phone interview on 6/3/23 at 6:27 p.m., the confidential complainant reported, They [facility staff] are not taking [R1's] preferences into account, and clarified R1 did not like the sandwiches, especially the bologna sandwiches, nor the cream of mushroom soup, which was frequently the only choice, canned gravy. The complainant clarified R1 had a heart condition and lymphedema, and should be receiving a heart-healthy meal. The complainant stated there were sometimes alternative choices offered, but not always. Per the complainant, R1 stated, It's crap for food. The complainant reported, On Mother's Day (5/13/24), [R1] did not even get dinner, I went there at 4:30 p.m., they had juice boxes, a sandwich [on the hall] and explained, [R1] said, 'I am getting hungry and frustrated,' and she did not get a sack lunch like the other residents. R1 reportedly receiving nothing to eat for dinner and thought the afternoon snack was her dinner. Her nurse reportedly asked what happened at 6:30 p.m., and said, 'I'm going to have to scrounge her up some food from the staff potluck today. It was confirmed R1 received a sack lunch, but later in the evening, well after the other residents.<br><br>During a phone interview on 6/4/24 at approximately 3:00 p.m., Certified Dietary Manager (CDM) L acknowledged the residents received a bagged lunch passed by the Certified Nurse Aides (CNAs) on Mother's Day due to staff call-ins. CDM L confirmed R1's meal was not initially received, but clarified R1 received a bagged fried bologna sandwich meal later that evening, and reported she had a snack earlier that day. CDM L confirmed R1 was on a NAS (no added salt) diet, and this meant no extra salt packs, or extra food portions for salted food. CDM L conveyed they had no concern with R1 eating bologna sandwiches, cream of mushroom soup, bacon, or other salted food, and indicated the menu was adequate for R1 and a resident on an NAS diet. CDM L reported this alternate meal of fried bologna sandwich and cream of mushroom soup was considered adequate to meet the nutritional expectations for all facility residents.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 6/4/24 at 4:00 p.m., Staff G reported R1 told them they did not like the food, and reported they observed it was sometimes burnt, and there was not much food for the residents, who only had one choice for the meal most of the time. Staff G stated R1's family sometimes brought them food due to R1's food complaints. Staff G explained the dietary staff were allowed to leave the facility immediately after the dinner meal was served, so when residents had a food request for an alternate or for additional food, there was no kitchen staff available. Staff G clarified they had brought this to the Nursing Home Administrator's (NHA's) attention, and to the dietary staff, and were told this was acceptable. Staff G confirmed this resulted in an occasional missed meal for a resident when they did not like the meal being served, or no second helping was available when requested. When asked if any residents had missed a meal, Staff G reported R13 had missed extra food, as they had a big appetite and sometimes requested second helpings after staff had left the building.<br><br>R7<br><br>During an interview on 6/3/24 at 12:44 p.m., R7 was asked about the food at the facility. R7 stated, Sometimes it is good, and sometimes it is not. Some of them [the kitchen staff] can't cook so much. R7 reported she skipped the meals sometimes, as there were sandwiches for dinner, as she did not like most of them. R7 reported she would like a regular dinner, with a meat, potato and vegetable, and bean soup.<br><br>Review of R7's recent BIMS assessment revealed a score of 15/15, which revealed R7 was cognitively intact.<br><br>An observation of the kitchen on 6/3/24 with the NHA following the lunch meal revealed an ample supply and variety of snacks, and an Always Available alternate menu, when requested. This included always available items like soup, peanut butter sandwiches, and items available upon request, including chicken patties, hot dogs, and hamburgers. The NHA reported they had distributed this to the facility residents, and these items were 'always available'. The NHA showed this Surveyor a one-page, undated paper which showed if residents wanted the meal or an alternate, and reported it was from today, and the CNA's had queried residents about the meal choices each day. Surveyor asked for the past two weeks of logs, and the NHA reported they were not saved and discarded daily. The NHA clarified they were the contact person for any food concerns, as they were acting supervisor of the dietary department, as the Director of Nursing (DON) would soon be assuming the role, however they were needed as a floor nurse to work the midnight shift this week.<br><br>Review of the four-week menus, provided by the NHA on 6/3/24, revealed a four-week menu cycle, which was reportedly repeated each month. The menus provided were labeled on the top of each page (four total), Flexible Menu Fall/Winter 2019 -2020. It was noted there was an entree for each meal, however there was no alternate listed, or second meal choice.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/3/24 at approximately 4:10 p.m., the NHA was asked for clarification, and reported the alternate was usually leftovers from the day before, and they kept leftovers and served them again for up to three days, and they were not on the menu as they were typically served until they ran out. The NHA confirmed the menus rotated each month to the same menus every four-week cycle. It was noted the menu showed the larger meal was served at lunch, a heavier meal with a meat, potato or rice and a vegetable with a roll, and a lighter meal was served at dinner, frequently soup and sandwiches, and a few other types, such as a burger, a hot dog, ravioli, pizza, or chili. The menu items were basic, such as lasagna, fish, meat loaf, goulash, sloppy joes, spaghetti, salisbury steak, chicken, pork, or meatballs. The NHA reported regionally these types of foods were resident-preferences, and the menus were reviewed with residents.<br><br>During a phone interview on 6/3/24 at 7:00 p.m., Staff D reported the menu was always the same each month, and rotated again the next month, and residents wanted more variety. Staff D reported the food had tons of salt, and residents were served a fruity drink mix sometimes, when they were supposed to be getting juice. Staff D explained, They [kitchen staff] cook for 27 residents and only have food for 27 residents. The NHA only buys enough food to cook for the number of residents. Anything else we cook extra we are told we are using too much . Staff D reported the alternates such as hot dogs could not be used per the NHA as they were needed for meals, and reported they could only use supplies for whatever was on the menu, so they could only give residents peanut butter and jelly sandwiches as the alternate. Staff D stated, We have the same food [for meals] we are giving as an alternate on the menu, like chicken noodle soup and a vegetable for dinner. Sometimes residents only get soup for dinner .<br><br>During an observation on 6/3/24 at approximately 5:30 p.m. this Surveyor taste tested a dinner tray provided by the NHA and kitchen staff. The NHA and kitchen staff reported there were two extra sandwiches and an extra beverage, with a choice of grape or cherry. Surveyor tested the bologna sandwich, with two slices of meat, which had cheese, lettuce and tomatoes, and the ham salad sandwiches, and the grape beverage. Surveyor noted the sandwich was adequate in presentation, and the sandwiches were palatable although both tasted salty, especially the ham salad sandwiches, and the juice tasted like Kool-aide and was not grape juice. There was also a cherry beverage available.<br><br>Review of the order supply sheets, requested for four weeks, showed orders for orange, apple, and cranberry juice, and for powered drink mixes, such as orange drink mix. The menus show a choice of juice and milk in the morning, and coffee or tea at dinner.<br><br>During a phone interview on 6/5/24 at 5:17 p.m., Staff M reported concerns related to residents not receiving adequate meals, portions, and alternates. Staff M reported there had been no always available menu for entrees, and when they had recently requested a hot dog for a resident, they were told by kitchen staff the package could not be opened for one serving. Staff M added in the past few weeks goulash was served three days in a row. Staff M clarified they only saw the Always Available alternate menu the week of the survey. Staff M stated there was no Dietary Manger in the kitchen for the past couple months. Staff M expressed frustration for the residents, as they were reportedly not receiving adequate food portions and palliative, nutritive food. Staff M continued, sometimes the food was served too early, due to kitchen staffing reasons, and there was too long a gap between dinner and breakfast when this occurred. Staff M conveyed they had reported their concerns to the NHA, especially during the past couple of months, and the situation had not resolved.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the policy, Know Your Rights, by the (State) Department of Community Health, revealed, As a resident of a Medicaid Nursing Home, you have the same rights about your life, medical care, and personal treatment as others who live in the community. These rights are protected by rules made by both the State and Federal government .Quality of Your Medical Care. You have the right to receive necessary nursing, medical, and social services to reach and maintain the highest practicable physical, mental, and social well-being .Food: Most types of food are supplied by the nursing home. Nursing Homes must provide substitutes to food you don't like .Some food and items the home must provide: Daily nutritious meals and snacks, reasonable food substitutes of a similar nutritive value, dietary supplements . |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>40330<br><br>This citation relates to Intake #MI00144651.<br><br>Based on observation, interview, and record review, the facility failed to act on a concern for one Resident (R8) of one resident reviewed for grievances. This deficient practice resulted in feelings of frustration for R8, and lack of timely follow-up for damaged clothing. Findings include:<br><br>Review of R8's recent BIMS assessment revealed a score of 15/15, which showed R15 was cognitively intact. R8 was interviewable and fully oriented.<br><br>During an interview on 6/3/24 at 2:46 p.m., R8 revealed he was the resident council president, and had a concern about his pajama pants and other items returning from the facility laundry with bleach stains. R8 explained they reported their concern to laundry staff about two weeks prior and had not received any explanation of his pants being ruined, or follow-up, and expressed feeling frustrated.<br><br>During an observation on 6/3/24 at 2:50 p.m., R8's red and black checkered pajama pants were observed in his closet with his permission. The pants had three holes in them, and there were bleach stains on the lower pant legs, at least 6 up on one side covering the pant leg. The threading was worn thin and the bottom of the pant legs were frayed. R8 reported he could not wear the pants anymore. It appeared the pants were damaged beyond wearing and needed to be replaced. R8 confirmed his pants had been sent to laundry undamaged.<br><br>During an interview on 6/3/24 at 3:25 p.m., Laundry Staff B was asked about R8's damaged pants. Staff B reported R8 had made her aware of the concern over a week before, and acknowledged they were recently damaged by bleach in the laundry. Staff B explained the normal process was to report the concern to the Business Office Manager, Staff F, who would follow-up. Staff B clarified they had not reported the damaged pants to Staff F, as they did not have time over a week prior when R8 told them, and they had been off work a week since then. Staff B reported they should have filed a grievance form and confirmed they did not file one.<br><br>During an interview on 6/03/24 at approximately 4:10 p.m., the Nursing Home Administrator (NHA) was asked about R8's damaged pajama pants, and the lack of follow-up. The NHA understood the concern, and reported they would replace R8's pants. The NHA confirmed the expectation was Staff B would have completed a grievance form and reported the damaged pants.<br><br>Review of the (State) nursing home publication, Know your Rights . by the (State) Department of Community Health, undated, revealed, Basic rights .You have the same rights about your life, medical care and personal treatment as others who live in the community. These rights are protected by rules made by the State and local government. You are entitled to a clean, home-like living space. You may keep and use personal clothing .The following must be provided by the nursing home .Laundry Services . |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>40330<br><br>This citation relates to Intake #Mi00144666 and #MI00144651.<br><br>Based on interview and record review, the facility failed to employ a qualified Certified Dietary Manager (CDM) to manage the food service department.<br><br>Findings include:<br><br>During the lunch meal on 6/3/24 at approximately 12:10 p.m., residents were asked about their meal. Five residents (R1, R2, R4, R6, and R7) reported concerns with minimal entree choices, limited or no alternates being offered, decreased palatability, and some missed meals due to the limited choices and poor quality of the food at some of the meals.<br><br>During an interview on 6/4/24 beginning at 12:40 p.m. Registered Dietician (RD) L confirmed the was no current CDM (Certified Dietary Manager) or DM (Dietary Manager) working in the food services department. RD L clarified a CDM or DM working on becoming certified was expected to be working in the food services department consistently and regularly and understood the concern. RD L explained they only worked four to eight hours per month and were not acting as the CDM at the facility. RD L reported the Director of Nursing (DON) had assumed the role of Dietary Manger and had enrolled in a CDM class but had not yet started the classes. During the interview, this Surveyor reviewed R4's significant weight loss with RD L of 5% in the past month. RD L acknowledged they were not notified of R4's significant weight loss in one month of 5%, and the expectation is they would be made aware. RD L reported there had been no nutritional supplementation added per standards of practice, other than vitamins, and reported they would be following up.<br><br>During an phone interview on 6/5/24 at 5:17 p.m., Staff M reported the Director of Nursing (DON) had been pulled from the DM role this past winter, around February, due to nursing staff needed to work on the midnight shift. Staff M reported they had intermittently observed or heard from the residents about food quality concerns, including inadequate food portions, palatability concerns, lack of consistent choices and alternates, and meal timeliness concerns. Staff M confirmed they were not aware of any foodborne illness.<br><br>During an interview on 6/4/24 at approximately 1:30 a.m., the Nursing Home Administrator (NHA) confirmed there was no acting CDM or DM in the facility, as the DON was working on the midnight shift during the survey. The NHA reported they oversaw the kitchen staff and food services department in the interim. The NHA was asked about resident-reported concerns related to limited choice, decreased palatability, timeliness, and some missed meals and R4's weight loss. The NHA denied the concerns, and reported the DON was unavailable for interview at that time as they were sleeping the next couple hours at least due to working the midnight shift. The NHA reported they could answer questions about the kitchen and food, as they were supervising the department. The NHA confirmed they were not a CDM or DM, and they had not enrolled in the dietary management classes. The NHA reported they were ordering the food, addressing the menus, scheduling staff, and completing all the DM roles in the absence of a working DM.<br><br>(continued on next page) |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 6/4/24 at approximately 5:15 p.m., the Regional Director of Operations, NHA, J, acknowledged there was no current acting CDM or DM in the facility recently, and understood the concern. NHA J reported they had not been made aware of resident-reported food concerns, or weight loss, and planned to follow-up. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Keep all essential equipment working safely.<br><br>40330<br><br>This citation relates to Intake #MI00144651.<br><br>Based on observation and interview, the facility failed to properly maintain resident equipment in safe, operating condition including two Residents (R2, R10) wheelchairs and residents' bed remote controls. This deficient practice resulted in two resident's wheelchairs being in disrepair, and the risk of injury to residents from lack of access to bed remote controls. Findings include:<br><br>R2<br><br>Review of the Electronic Medical Record (EMR) revealed R2 had a recent score of 15/15 on the Brief Interview for Mental Status (BIMS) assessment, which showed R2 was cognitively intact.<br><br>During an interview on 6/3/24 at 12:10 p.m., R2 was seated in a manual wheelchair at lunch, and reported staff were having problems operating their wheelchair. R2 stated, I have problems with the wheels on my wheelchair, it [the wheels] wants to go one way [to the side instead of straight].<br><br>During an observation on 6/3/24 at 12:15 p.m., R2's wheelchair was observed with worn wheels. There was no wheelchair cushion observed. R2 stated, I would like a wheelchair cushion. When I sit on it [the chair] it is very uncomfortable. R2 reported they did not have a bedsore. Surveyor did not test the wheelchair maneuverability at that time, as R2 was eating their lunch meal.<br><br>R10<br><br>Review of the EMR revealed R10 had a recent score of 13/15 on the BIMS assessment, which showed R10 was cognitively intact.<br><br>During an interview on 6/3/24 at approximately 3:10 p.m., R10 was asked about their care at the facility. R10 explained he was at the facility for therapy, and his wheelchair did not work, which concerned him as he was afraid of falling when the brakes did not lock. R10 added the brakes hurt his hands when he pushed them.<br><br>During an observation on 6/3/24 at approximately 3:15 p.m., this Surveyor observed R10's high back reclining wheelchair had no plastic or rubber break covers, only thin metal brakes which were typically covered on wheelchairs. It was observed the wheelchair appeared worn, with foam covers worn and frayed where the headrest was prior attached and cracked left armrest upholstery. With the brakes activated, it was apparent the left brake did not lock or 'hold', as the wheelchair slid backward when the brakes were applied. R10 reported he had made staff aware, and they could all see it happening when they transferred him and the brakes did not fully engage. It was observed there was no seat cushion in the chair. R10 reported he would like his wheelchair repaired, and a cushion for comfort.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235543 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lincoln Haven Nursing and Rehabilitation Community | 950 Barlow Rd<br>Lincoln, MI 48742 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation on 6/3/24 beginning at 3:30 p.m., the Maintenance Director, Staff C was asked to observe R2's and R10's wheelchair with this Surveyor. Staff C confirmed both wheelchairs needed repair and observed the concerns regarding R2's wheelchair turning to the side when pushed forward, and R10's wheelchair brake not locking, the sharp metal edge where the headrest had been attached, covered by broken foam, no wheelchair brake covers, and no wheelchair cushions in both wheelchairs. The Nursing Home Administrator (NHA) arrived and observed the same concerns and planned to follow-up.<br><br>Bed remote concerns<br><br>During a phone interview on 6/4/24 at approximately 3:50 p.m., Staff G reported they learned several of the bed remotes were not working in the past few months, and Staff C was only able to order one replacement at a time per the NHA.<br><br>During an interview on 6/4/24 at approximately 4:30 p.m., Staff C was asked if residents' bed remotes were removed from the residents' beds in the facility. Staff C confirmed they removed all the remotes from the residents' beds per the NHA, after the facility received a citation from the annual survey related to a hospital bed remote. Staff C stated, Our administrator made us pull all the remotes from the beds and I put them back on the same day, only a few hours later. Staff C confirmed the remotes were removed from all the residents' beds, not just those with cognitive impairment. Staff C was asked if this was a concern for any the residents, not being able to operate their bed remotes, especially for those who could do so independently. Staff C reported they did not hear resident complaints, but the staff reported concerns. Staff C stated they were removed to repair them, and there were no resident falls or other outcomes per their awareness. Staff C stated the NHA told them they could only order one bed remote a month for those which were in disrepair, so they did some finagling and switching of the bed remotes in lieu of replacement, which was needed for some of the remotes, and reported was not ideal.<br><br>During an interview on 6/4/24 at approximately 5:30 p.m., the Regional Director of Operations, NHA J, was asked about the equipment concerns, and confirmed they were investigating administrative and employee concerns brought forward by facility staff. NHA J reported they had rounded the facility including equipment concerns on 6/4/24 and had found one bed remote not working, which they were addressing. NHA J reported their Director of Environment would be following up on any environmental concerns including equipment the next day.<br><br>During a phone interview on 6/5/24 at 5:17 p.m., Staff M reported concerns regarding all the residents bed remotes being removed from the walls by directive of the NHA to maintenance staff. Staff M reported afterwards the cords were messed up and they were finicky on working since we got a citation. The Administrator pulled the bed remotes off the beds as part of her Plan of Correction and put three at the desk and made the aides share them. Staff M clarified the bed remotes were pulled off all the beds, for all the residents, not just the ones in the citations. Staff M noted they had trouble providing care for an ill, dependent resident because their bed was too low, and it took over 45 minutes to get a remote to feed the resident and provide care. Staff M reported the remotes were off the beds over 24 hours, and they were unaware of any accidents from this, or other outcomes. Staff M reported they and the aides had trouble getting to the remotes after they were replaced, causing awkward body mechanics, as they were zip tied under the beds when they were added back, and they were told they would be fired if they cut the zip ties. |