STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235551	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree of Hubbell Rehab and Health	52225 B Avenue Hubbell, MI 49934

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to MI00142942. Based on observation, interview and record review the facility failed to ensure a call light was within reach for one visually impaired resident (R16) of three residents reviewed for call light use. This deficient practice resulted in the potential for fear and feelings of helplessness, frustration and anxiety. Findings include: R16 was admitted to the facility on [DATE] and had diagnoses including legal blindness, dementia, anxiety and depression. Review of R16's most recent MDS (Minimum Data Set) assessment, dated 1/23/2024, revealed R16 used a manual wheelchair and was dependent on staff for wheelchair mobility and required substantial/maximal assistance with transfers. Further review of the MDS assessment revealed R16 had highly impaired vision and scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating she was cognitively intact. An observation on 4/15/2024 at 2:25 p.m. revealed R16 sitting in a wheelchair in her room, facing the wall near the head of her bed with an over bed table directly in front of her. R16 reported being legally blind and requiring staff assistance for toileting and mobility. When asked how she asked for assistance, R16 was observed patting her hands around her lap and the table in front of her. R16 stated she was attempting to find the call light. Further observation revealed R16's call light wrapped around the left upper grab bar of the resident's bed, on the opposite side of the over bed table from where the resident was sitting. The call light was observed to be out of reach of the resident. When asked how often she is unable to find the call light, R16 stated she often is unable to locate the call light. On 4/16/2024 at 1:25 p.m. while standing in the hallway near the Hall-A nurse's station, a resident could be heard calling, can someone help me, repeatedly. Upon inspection of the direction of the voice, an observation revealed R16 sitting in her room in a wheelchair with the over bed table positioned in front of her, as per the previous observation on 4/15/2024 at 2:25 p.m. R16 was rocking gently back and forth in her wheelchair calling, can someone help me. A lunch tray was observed on the over bed table in front of the resident. R16 reported she finished lunch and would like to go back to bed but required staff assistance. R16 was observed patting around her lap and the over bed table with her hands and reported she did not know where her call light was. Further observation revealed R16's call light lying on the floor approximately two feet in front of the resident and on the opposite side of the over bed table from where the resident was positioned. When asked if she would like assistance calling for help, R16 stated I wish I could do it myself. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation with Licensed Practical Nurse (LPN) C on 4/16/2024 at 1:28 p.m. revealed R16 still seated per the previous observation with the call light still on the floor approximately two feet in front of the resident and on the opposite side of the over bed table from where R16 was positioned. R16 reported to LPN C she could not find her call light and she would like to go back to bed. LPN C picked the call light up off the floor and activated the light for assistance transferring R16 back to bed. When asked if there was a device present to secure the call light near the resident, LPN C proceeded to inspect the call light cord and found a small metal clip for securing the light. The clip was observed to be at the opposite end of the cord from the activation button, near the entry point of the cord into the wall. In an interview immediately following the observation, LPN C confirmed R16 was unable to see the call light due to having severe visual impairment. During an interview on 4/16/2024 at 2:00 p.m., the Director of Nursing (DON) reported call lights should always be accessible to residents. The DON confirmed R16 had severe visual impairment and the call light should be secured near the resident to ensure accessibility.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intakes MI00142825 and MI00143791. Based on observation, interview and record review the facility failed to ensure privacy and dignified treatment during the provision of care for two residents (R12 and R15) of three residents reviewed for dignity. Findings include: R12 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, stroke, peripheral vascular disease, anxiety and depression. Review of R12's most recent MDS (Minimum Data Set) assessment, dated 1/09/2024, revealed R12 was dependent on staff for upper and lower body dressing, personal and toileting hygiene, repositioning, and mobility. Further review of the MDS assessment revealed R12 was assessed as always incontinent of bladder and bowel and had severe cognitive impairment. An observation on 4/16/2024 at 11:21 a.m. revealed Certified Nurse Aide (CNA) H and the Nursing Home Administrator (NHA) providing incontinence care to R12. Upon completion of care, CNA H left the room and immediately returned and reported she needed to recheck R12 for cleanliness. CNA H stood to the right of R12's bed while the NHA assisted from the left side of R12 and removed the resident's pants, unfastened R12's brief and tucked the brief between the resident's upper thighs, exposing R12's pubic area. The NHA then left R12's bedside to retrieve a clean brief from the resident's closet while CNA H proceeded to cleanse R12's peri-area then walked to the sink behind the head of R12's bed to wash her hands. R12 was observed to be lying in bed, naked from the waist down while CNA H was at the sink performing hand hygiene and the NHA was looking for a brief in the closet. Both CNA H and the NHA were out of R12's sight while she was lying on the bed exposed from the waist down. R15 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease. Review of R15's most recent MDS assessment, dated 2/8/2024, revealed R15 was independent for toileting hygiene and was occasionally incontinent of bladder and bowel. Further review of R15's MDS assessment revealed R15 had severe cognitive impairment. An observation from the hallway outside the B-Hall shower room, on 4/16/2024 at 1:10 p.m., revealed R15 sitting on the toilet with CNA J standing directly in front of the seated resident. Further observation revealed R15's pants and brief were pulled down below her knees, exposing the resident's lower body as she sat on the toilet. The privacy curtain was not drawn and the door to the shower room was fully ajar, causing R15 to be fully visible from the hallway. During the observation, Maintenance Director (Staff) L was observed walking down B-Hall, looking into the shower room where R15 was seated on the toilet with her pants and brief pulled down. Staff L was heard mumbling R15's name and observed shaking his head before walking into the shower room next to the resident seated on the toilet and drawing the privacy curtain. Staff L then exited the shower room. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/2024 at 2:00 p.m., the Director of Nursing (DON) reported all residents should be cared for in a manner that preserves the resident's dignity. The DON stated ensuring dignity as a standard of practice which included the provision of privacy while toileting and covering exposed body parts while performing other tasks during bathing and incontinence care. A review of the facility policy titled Promoting/Maintaining Resident Dignity, provided by the NHA and dated 2/07/2023, revealed the following, in part: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity . 1. All staff members are involved in providing care to residents to promote and maintain resident dignity . 12. Maintain resident privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intake MI00142941. Based on observation, interview and record review, the facility failed to ensure resident rooms were maintained in a safe, clean, and homelike manner for two Residents (R13 and R19) of three residents reviewed. This deficient practice resulted in the potential for feelings of worthlessness, embarrassment and loss of dignity. Findings include: R13 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, stroke, peripheral vascular disease, anxiety and depression. A review of R13's most recent MDS (Minimum Data Set) assessment, dated 1/9/2024, revealed R13 had severe cognitive impairment. A review of R13's care plan revealed the following, in part: Focus: I have a self-care performance deficit r/t (related to) dementia, Parkinson's. Date Initiated: 12/23/2023 . Interventions/Tasks: My mattress is on the floor and I will crawl off my mattress across the floor independently . R19 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), bipolar disorder and depression. A review of R19's most recent MDS assessment, dated 3/25/2024, revealed R19 was cognitively intact. An observation on 4/16/2024 at 8:05 a.m. revealed R13's mattress positioned directly on the floor in her room. The mattress was not covered by sheets, or a mattress protector and an uncovered pillow was resting on top of the mattress. A fall mat was folded in half and placed on the floor in the left corner of R13's room, while another fall mat was lying on the floor directly to the right of the mattress, with the mattress resting on top of the fall mat. Further observation revealed the mattress and the fall mat on the right were positioned askew on the floor with a portion of the mattress resting under the privacy curtain and protruding into R19's portion of the room. The floor surrounding R13's mattress was observed to be visibly soiled and multiple shoe prints could be seen on the dirty floor. A sticking sound was noted while walking on the visibly soiled floor surrounding R13's mattress. An observation on 4/16/2024 at 8:18 a.m., revealed R19 sitting on the edge of her bed on the opposite side of the privacy curtain from R13's portion of the room. Further observation revealed R13's mattress and fall mat protruding from under the privacy curtain and into R19's portion of the room. The floor on R19's side of the room was visibly soiled with dirt and a sticking sound was noted upon walking on the floor. The wall to the left of R19's dresser was observed to have deep gouges where paint and drywall were removed and there was an uncovered utility box directly to the left of R19's dresser, approximately 12 inches above the floor. Further observation revealed a screw protruding out approximately one inch from the top portion of the utility box. Inside the utility box was a gray cord. During an interview at the time of the observation, R19 was asked if the condition of her room and the protrusion of R13's mattress into her living space bothered her. R19 reported she preferred R13's mattress remain out of her living space as it was difficult to maneuver her wheelchair around the mattress on the floor. R19 stated she reported the concern to staff in the past but it didn't' do any good. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately following the observation, Certified Nurse Aide Supervisor (CNA) F was queried as to why R13's mattress was directly on the floor. CNA F reported R13 consistently crawled out of bed and slept on the floor, therefore she was care planned to have her mattress directly on the floor. CNA F stated R13 often crawled around on the floor in her room. During an observation at the time of the interview, CNA F confirmed R13's uncovered mattress was protruding under the privacy curtain and into R19's portion of the room. During an interview on 4/16/2024 at 8:23 a.m., Maintenance and Housekeeping Director (Staff) L was called to R13 and R19's room. Staff L inspected the wall near R19's dresser and reported he was unaware of the uncovered outlet box and of the amount of disrepair in R13 and R19's room. Staff L stated the utility box contained an old phone cable and should have a cover over the opening in the wall. Staff L confirmed the floor in the room was visibly soiled including the area surrounding R13's mattress. Staff L reported staff should be alert to soiled floors and any needs reported to housekeeping for priority clean up and if housekeeping was unavailable, all staff have access to housekeeping supplies and equipment. During an interview on 4/16/2024 at 8:25 a.m., Housekeeping Aide (Staff) T reported she did not receive notification from staff of the visibly soiled floor in R13 and R19's room, therefore she did not prioritize the room for cleaning. During an interview on 4/16/2024 at 8:32 a.m., Housekeeping Aide (Staff) S stated R13 and R19's room was last cleaned on 4/15/2024. Staff S did not remember what time she cleaned the room on 4/15/2024. Staff S reported she did not receive notification R13 and R19's floor was visibly soiled and in need of cleaning after servicing the room on 4/15/2024. A review of the facility Maintenance Log, for the dates 1/01/2024 through 4/16/2024, provided by Staff L, revealed no log entry for the problem of the uncovered outlet box or the deep gouges in the wall of R13 and R19's room. During an interview on 4/16/2024 at 4:00 p.m., the Nursing Home Administrator (NHA) and Regional Administrative Consultant (Staff) A reported upon this Surveyor's observations of R13 and R19's room, maintenance staff were instructed to begin a facility-wide inspection of all utility outlets and housekeeping staff were instructed to begin twice daily cleaning of R13 and R19's room. The NHA confirmed R13's mattress rested directly on the floor and the Resident often crawled out of bed onto the floor therefore staff should be alert as to the condition of the floor in R13's room.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intake MI00142941 and MI00143791. Based on observation, interview and record review the facility failed to ensure safe transfers for two Residents (R13 and R18) of three residents reviewed for safety during transfers. This deficient practice resulted in the potential for falls and injury. Findings include: R13 was admitted to the facility on [DATE] and had diagnoses including dementia, Parkinson's disease, muscle weakness and abnormalities of gait/mobility. Review of R13's Minimum Data Set (MDS) assessment, dated 2/15/2024, revealed R13 required substantial/maximal assistance to transfer from sitting to standing and had two or more falls since admission. Further review of the MDS assessment revealed R13 had severe cognitive impairment. An observation on 4/15/2024 at 1:45 p.m., revealed R13 being assisted to the toilet in the shower room on B-Hall by Certified Nurse Aide (CNA) G and CNA D. R13 was observed to be fully seated at approximately 80 degrees in a high-back wheelchair positioned in front of the toilet. CNA D stood behind R13's wheelchair while CNA G stood in front of R13's wheelchair and asked the Resident to grab his hands. R13 was observed placing her hands in CNA G's hands and CNA G was observed holding onto R13's hands and pulling R13 to standing position. CNA G did not use a gait belt to assist R13 to transfer from sitting to standing position. CNA D continued to stand behind R13's wheelchair and did not assist with the transfer. A review of R13's care plan revealed the following, in part: Focus: I have an ADL [Activities of Daily Living] self-care performance deficit related to dementia, Parkinson's. Date Initiated: 12/23/2023 . Interventions/Tasks: Transfer - Extensive assistance of 1 stand pivot. Encourage resident to assist with using arms to push to stand . Date Initiated: 12/23/2023. A review of R13's Fall Risk Evaluation, dated 4/06/2024, revealed R13 was at high risk for falls. R18 was admitted to the facility on [DATE] and had diagnoses including severe dementia with other behavioral disturbance. A review of R18's MDS assessment, dated 4/17/2024, revealed R18 required substantial/maximal assistance to transfer from sitting to standing and had one fall since admission. Further review of the MDS assessment revealed R18 had severely impaired cognition. An observation on 4/16/2024 at 8:49 a.m., revealed CNA K assisting R18 to transfer from a wheelchair to the bed. R18 was seated in the wheelchair with her right side next to the head of her bed. CNA K stood in front of R18, placed her arms under the Resident's arms then pulled R18 to standing position then pivoted so the back of R18's thighs were touching the mattress. CNA K then lowered the resident to seated position on the bed. CNA K did not use a gait belt or any other assistive device during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview immediately following the observation, CNA K reported she was unsure of what level of assistance R18 needed during transfers. CNA K reported she did not receive a report from the previous shift and did not know what R18's care planned interventions were regarding ADL assistance and transfer status. A review of R18's care plan revealed the following, in part: Focus: I have an ADL self-care performance deficit r/t [sic]. Date Initiated: 4/12/2024 . Interventions/Tasks: Transfers - Assist x 1, utilize gait belt and FWW [front-wheeled walker] for transfers. Date Initiated: 4/12/2024. A review of R18's Fall Risk Evaluation, dated 4/13/2024, revealed R18 was at high risk for falls. During an interview on 4/16/2024 at 2:00 p.m., the Director of Nursing (DON) reported the use of gait belts while transferring residents was a standard of practice. The DON stated staff should be checking the care plan when unsure of resident's transfer status prior to transferring a resident. A review of the facility policy titled Safe Resident Handling/Transfer, provided by the Nursing Home Administrator (NHA) and last reviewed 6/25/2023, revealed the following, in part: It is the policy of this facility to ensure that resident are handled and transferred safely to prevent or minimize risks for injury and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines . Handling aids may include gait belts, transfer boards and other devices . Resident lifting and transferring will be performed according to the resident's individual plan of care .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41978 This citation pertains to intake MI00143791. Based on interview and record review, the facility failed to perform pre-employment and pre-admission screenings for tuberculosis (a contagious infection affecting the lungs) based on current professional guidelines. This deficient practice resulted in the potential for exposure and transmission of tuberculosis to susceptible residents residing in the facility. Findings include: On 4/17/2024 at 9:53 a.m., the staff tuberculosis (TB) screening document binder was reviewed with Office Manager (Staff) E. Upon review of a selection of staff beginning work in January 2024 through April 2024, it was noted no TB screening information was found for the sampled employees. Staff E reported the head of each department was responsible for ensuring appropriate TB screening for newly hired staff. Once completed, the screenings documented were provided to Staff E for filing in the binder. Staff E confirmed she did not have TB screenings for the following staff members who began working inside the facility in April 2024: Dietary Aide (Staff) N, first day of work in facility: 4/15/2024. Certified Nurse Aide (CNA) Q, first day of work in facility: 4/12/2024. CNA R, first day of work in facility: 4/12/2024. CNA O, first day of work in facility: 4/14/2024. Housekeeping Aide (Staff) P, first day of work in facility: 2/28/2024. During an interview on 4/17/2024 at 10:00 a.m., the Nursing Home Administrator (NHA) reported she was also the interim Infection Preventionist for the facility. The NHA reported she recognized concerns with the facility's TB screening process during an infection control audit a couple weeks ago, although no changes to the process were made as of the date of this survey. The NHA reported she checked with each department head to inquire if any TB screening information was obtained prior to the sample staff beginning work in the facility. The NHA confirmed there was no TB screening information found for Staff N, CNA Q, CNA R, CNA O or Staff P. A review of the electronic medication records (EMR's) was conducted for residents with an initial admitted within the past 30-day period prior to the survey dated 4/17/2024. The following residents did not have information in the EMR regarding TB screening prior to admission: Resident 18 (R18), initial admitted : 4/10/2024. R22, initial admitted : 4/09/2024. R23, initial admitted : 4/01/2024. R24, initial admitted : 4/04/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25, initial admitted : 3/27/2024. During an interview on 4/17/2024 at 10:45 a.m., the NHA confirmed R18, R22, R23, R24 and R25 were not screened for TB prior to or since admission to the facility. The NHA reported the staff responsible for ensuring TB screening of newly hired staff and newly admitted residents did not understand the process for TB screening. Review of the facility policy titled Administration and Interpretation of Tuberculin Skin Tests, provided by the NHA and last reviewed 3/18/2024, revealed the following, in part: This facility administers and interprets tuberculin skin tests (TST) in accordance with current CDC [Centers for Disease Control and Prevention] guidelines and/or state/federal regulations. Healthcare Personnel: Should receive a baseline individual TB risk assessment, symptom screening and TB testing (e.g. TB skin test or TB blood test) upon hire/pre-placement . Residents: Residents should be screened for TB in accordance with CDC recommendations . This may consist of an intradermal skin test, a blood test, a chest x-ray, or other methods recommended by the public health authority . Review of the CDC guideline titled TB Screening and Testing of Health Care Personnel, last updated 8/30/2022, revealed the following, in part: All U.S. health care personnel should be screened for TB upon hire (i.e., preplacement). TB screening is a process that includes: A baseline individual TB risk assessment; TB symptom evaluation; A TB test (e.g., TB blood test or a TB skin test; and Additional evaluation for TB disease as needed. Review of the CDC guideline titled Who Should be tested for TB Infection, last reviewed 4/14/2016, revealed the following, in part: Certain people should be tested for TB infection because they are at higher risk for being infected with TB bacteria, including: People who live or work in high-risk settings (for example: correctional facilities, long-term care facilities or nursing homes, and homeless shelters) . Health-care workers who care for patients at increased risk for TB disease .