

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  Fountain Bleu Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 28910 Plymouth Road Livonia, MI 48150	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44750</p> <p>Based on observation, interview, and record review, the facility failed to implement dietary care plan interventions for one residents (R22) out of two reviewed for care plans. Findings include:</p> <p>R22</p> <p>On 8/13/2024 at 12:41 PM, R22 was observed in their room eating lunch. R22's meal ticket stated, No straws. R22 was observed to have a cup of water dated 8/13/2024 with a straw in it.</p> <p>A review of the medical record revealed that R22 admitted into the facility on [DATE] with the following diagnoses, Dysphagia and Multiple Sclerosis. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 9/15 indicating an impaired cognition. R9 also required staff assistance with bed mobility and transfers.</p> <p>Further review of R22's diet order noted the following, Order: Regular diet, Mechanical Soft texture, thin consistency. Directions: No straws for nutrition. Status: Active</p> <p>A review of the nutrition care plan revealed the following intervention, Provide regular diet, mechanical soft texture, thin liquids. No straws per SLP (Speech Language Pathologist). Date initiated: 3/23/2023.</p> <p>On 8/13/2024 at 1:04 PM, R22 was observed taking a drink of water from the straw. Registered Nurse (RN) A was brought into room and shown R22 drinking out of straw. RN A stated the assigned certified nursing assistant (CNA) brought R22 the straw. RN A was noted to take the straw out of R22's water cup.</p> <p>On 8/14/2024 at 12:55 PM and 1:30 PM, R22 was observed eating lunch. A straw was observed in their water cup on their nightstand.</p> <p>On 8/15/2024 at 9:29 AM, R22 was observed up in their wheelchair. Licensed Practical Nurse (LPN) C was observed getting vital signs on R22. A straw was noted to be in the water cup. LPN C was asked if R22 should have a straw in their beverages. LPN C stated R22 should not have a straw and they told the CNA this already. LPN C was observed taking the straw out of the water.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/15/2024 at 9:49 AM, an interview was conducted with Registered Dietitian (RD) B. RD B stated R22 spoke with the speech therapist and the no straw order is going to stay active because of R22's long history with aspiration (choking) and the straw is just to fast, which causes R22 to choke.</p> <p>A review of the nutrition care plan revealed the following intervention, Provide regular diet, mechanical soft texture, thin liquids. No straws per SLP (Speech Language Pathologist). Date initiated: 3/23/2023.</p> <p>A review of a facility policy titled, Nutritional Management noted the following, b. Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to: i.Diet liberalization unless the resident's medical condition warrants a therapeutic diet ii.Alterd-consistency food/liquids after underlying causes of symptoms are addressed (i.e. new dentures, dental consult, dysphagia therapy) iii.Weight-related interventions iv.Environmental interventions v.Disease-specific interventions vi.Physical assistance or provision of assistive devices vii.Interventions to address food-drug interactions or medication side effects.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40384</p> <p>Based on observation, interview and record review, the facility failed to revise an individualized, person-centered care plan for one resident (R8) of two residents reviewed for care plans. Findings include:</p> <p>On 8/14/24 at 11:39 AM, R8 was observed lying in bed asleep on a perimeter mattress without heel protectors.</p> <p>A review of R8's medical record revealed R8 was admitted into the facility on [DATE] with diagnoses which included Alzheimer's Disease, Hypertension, and Muscle Weakness. Further review revealed the resident was significantly cognitively impaired, and required one person assistance for bed mobility.</p> <p>Further review of R8's medical record revealed the following care plan, Actual Pressure Ulcer Formation Related</p> <p>to: Resident was admitted with or has pressure ulcer, with risk for delayed wound healing secondary to progressing</p> <p>comorbidities, Debility and generalized weakness with decreased physical mobility and bowel/ bladder incontinence daily. Resident has pressure ulcer/ wound Left Foot. Update 11/21/22 Resident has history of PVD (peripheral vascular disease). Vascular ulcers to left lateral foot and left lateral ankle as [their] clinical status declines resident is at risk for unavoidable further skin breakdown. Date Initiated: 10/26/2022 . Interventions: bilateral heel protectors as tolerated. Date Initiated: 10/26/2022. Encourage resident to float heels and /or wear heel boots. Date Initiated: 10/26/2022. Low Air Loss mattress. Date Initiated: 10/26/2022 .</p> <p>Further review of R8's medical record revealed an active physician order dated 10/26/22 revealing the following, Order Summary: Air Loss Mattress.</p> <p>On 8/14/24 at 12:52 PM, an observation of R8's mattress did not reveal an air loss mattress in place.</p> <p>On 8/15/24 at 9:17 AM, an observation of R8's mattress did not reveal an air loss mattress in place.</p> <p>On 8/15/24 at 3:42 PM, the Director of Nursing (DON) and Licensed Practical Nurse (LPN B) explained the resident no longer needs the air loss mattress as their wound has healed. They both acknowledged the care plan should have been updated to reflect the resident's current status.</p> <p>A review of the facility's Care Plan-Comprehensive and Revision policy revealed the following, .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. The interdisciplinary team reviews and updates the care plan:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>o When there has been a significant change in the resident ' s condition.</li> <li>o When the desired outcome is not met.</li> <li>o When the resident has been readmitted to the facility from a hospital stay.</li> <li>o At least quarterly, in conjunction with the required quarterly MDS assessment .</li> </ul>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34851</p> <p>Based on observation, interview, and record review, the facility failed to ensure safety during a transfer for one sampled resident (R26) of six reviewed for accidents, resulting in a laceration to the head and emergency transfer to the hospital. Findings include:</p> <p>R26</p> <p>On 8/13/24 at 10:06 AM, R26 was asked about the care at the facility. R26 stated, I had a really bad fall, the sling broke. R26 explained they had a fall during a transfer using the sit to stand lift. R26 was asked if they were hurt during that fall. R26 explained, they had a head injury. R26 was asked how many staff were with her to help with the transfer. R26 stated, It may have been one person. They don't want to ask for help Because they say they are short (staff).</p> <p>A review of the incident and accident report noted, Incident Description. Nursing Description: Writer called in the room at approximately 10:45 am. Writer entered room, resident lying flat on [R26's] back on the floor, with Aide (Certified Nursing Assistant), two nurses, and restorative aide present. Resident observed bleeding from the back of [their] head. Laceration observed. Unable to measure due to hair, bleeding, and unable to move resident for safety. 911 called for further evaluation. Resident Description: Resident alert and oriented x3 able to make needs known. Per resident, [they] was with Aide (CNA F) and being transferred from bed to chair using a sit to stand lift. Per resident, [they] was unable to hold on, slipped under the sling, fell on [their] buttocks, then fell backwards, hitting head to the bottom corner of the bedside dresser. Immediate Action Taken: VS (vital signs) taken, Resident denies any dizziness, blurry vision. Neuro Checks initiated. ROM (Range of Motion) to BLE (bilateral lower extremities) assessed . Resident c/o (complained of) pain to back of head. Applied pressure to back of head . Resident taken to hospital? Y (yes) .</p> <p>A review of the hospital discharge summary dated 12/8/2023, revealed, Your evaluated in the ED (emergency department) for a fall and subsequent head laceration. Your scalp required complex sutures (stiches) and special dressing . Bruising will be anticipated near your head injury is and you might have some hair loss .</p> <p>A review of R26's medical record revealed, Progress notes: 12/8/2023 16:28 Nursing Progress Note: @ (at) 1620 resident returned to facility accompanied by two EMS (emergency medical service) paramedics with instructions. Instructions detail how to take care, replace, and properly maintain head bandage which can be found in the unit clerks basket. Resident is sitting upright in wheelchair watching television. No further new orders will continue to monitor and maintain safety.</p> <p>Further review of R26's medical record noted, R26 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Chronic Kidney Disease, Stage 4. A review of R27's Minimum Data set noted R26's ability for sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or the side of the bed: Dependent.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of R26's care plan noted, Focus: Alteration in Mobility r/t (related to): Resident has Impaired with limited mobility/ROM (range of motion) to both lower extremities to both knees and ankle, and limited ROM to left shoulder. Date Initiated: 09/21/2020. Goal: Resident will continue to participate in ADLs within functional mobility daily x 90 days. Date Initiated: 09/21/2020. Interventions: Assess need for and provide as indicated adaptive devices for mobility. Date Initiated: 09/21/2020. Focus: Resident has A Scalp laceration on head. No treatment needed. Date Initiated: 12/09/2023. Goal: Will heal within the limits of disease process. Date Initiated: 12/11/2023. Interventions: report evidence of infection such as prurient drainage, swelling, localized heat, increase pain, etc (et cetera), Notify physician prn (as needed).</p> <p>On 8/15/24 at 1:57 PM, the Therapy Director was asked how many staff are required to use the sit to stand lift. The Therapy Director explained, it can be one to two but, it depends on the resident. The Therapy Director was asked for clarification and ask if one staff could transfer a resident using a sit to stand lift. The Therapy Director stated, Well I don't think we have anyone that is one a person (transfer with lift). The Therapy Director was asked R26's transfer status at the time of the fall. The Therapy Director reported, We discharged [R26] from therapy on 10/31 and they were a sit to stand with two staff.</p> <p>On 8/15/24 at 2:14 PM, the Director of Nursing (DON) was asked the facility's expectations for the number of staff during a transfer with a sit to stand lift. The DON explained, any staff that uses a device should have two staff.</p> <p>On 8/15/24 at 2:24 PM, Licensed Practical Nurse (LPN E) was asked about the fall with R26. LPN E stated, The aide had came and got me and said that she needed help because she had a fall. LPN E was asked if CNA F was alone. LPN E stated, She was alone when I walked in. LPN E stated, [R26] was laying on the floor bleeding, we didn't move [R26] we let the EMS move [R26]. I took the vitals and made sure [R26] was still alert. LPN E was asked if CNA F was required to have one or two with a sit to stand lift and explained, CNA F is required to have two people to prevent accidents and for safety.</p> <p>On 8/15/24 at 3:04 PM, CNA F was called via phone a error message was received from CNA F's phone.</p> <p>A review of the facility's policy titled, Activities of Daily Living (ADL) dated 8/21/2023, noted, Policy overview: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene . The policy did not address the use of a mechanical lift.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49699</p> <p>Based on observation, interview, and record review, the facility failed to ensure three residents (R11, R13, R64) of three residents reviewed, call lights were accessible. Findings include:</p> <p><b>R11</b></p> <p>A review of the facility record revealed R11 admitted into the facility on [DATE]. R11's relevant diagnoses include vascular dementia, muscle weakness, diabetes, psychotic disorder, and failure to thrive. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 00/15 indicating an severely impaired cognition. A review of R11's care plan indicated they required a two-person assist for bed mobility.</p> <p>On 8/13/2024 at 11:50 AM, an observation revealed the call light was hanging, tied to the left bed assist rail, touching the floor.</p> <p>On 8/14/2024 at 10:47 AM, an observation revealed R11's call light was tied to the left bed assist bar, hanging, touching the floor, out of resident reach. Head of bed was elevated to 90 degrees, R11 was awake and conversant. An inquiry of resident to press the call light, revealed she was unable to locate it. When queried how they would let staff know they were needed, they revealed, I yell.</p> <p>On 8/14/2024 at 02:12 PM, an observation revealed that R11's call light was tied to bed assist rail, hanging to the floor. Certified Nurse Assistant (CNA) A revealed they check on R11 every 2 hours and R11 does not use call light, they just check on them often.</p> <p><b>R13</b></p> <p>A review of the facility record revealed R13 was admitted into the facility on [DATE] with diagnoses which included, dementia, frontal lobe and executive function deficit with speech and language deficits following cerebral infarction (stroke). A review of the Brief Inventory of Mental Status revealed a score of 00 indicating severely impaired cognition. A review of R13's care plan indicated a two-person assist was required for bed mobility.</p> <p>On 08/13/24 at 09:50 AM, upon entering R13's room meet with an individual identifying themselves as R13's family member. When queried regarding the call light, the family member looked for the device around R13's upper body and bed. They were unable to locate the light.</p> <p>On 8/14/2024 at 8:30 AM, 10:52 AM, and 2:00 PM, observations revealed a soft touch call light lying behind the oxygen concentrator on the floor.</p> <p>On 8/15/2024 at 8:55 AM an observation revealed R13 had received morning care. R13's call light was still located behind the oxygen concentrator on the floor.</p> <p><b>R34</b></p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility record revealed R34 was admitted into the facility on [DATE]. A further review revealed the following pertinent diagnoses: vascular dementia, cerebral infarction (stroke), anxiety disorder, difficulty walking, adjustment disorder with anxiety and depression. The facility record revealed a Brief Inventory of Mental Status score to be 03/15 indicating severely impaired cognition A review of R34's care plan indicated a one-person assist was required for bed mobility.</p> <p>On 8/13/2024 at 11:55 AM, an observation revealed resident call light was under the bed covers at the bottom of the bed. R34 was asked if they could reach the call light and though attempted, was unable to locate it.</p> <p>On 8/13/2024 at 1:53 PM, an observation revealed resident was in previous position, call light under covers out of the resident's reach.</p> <p>On 8/14/2024 at 8:34 AM, an observation revealed R34's call light was lying on the floor at the foot of the bed.</p> <p>On 8/14/2024 at 10:44 AM, R34's call light was on the floor at the foot of the bed. R34 was asked if they could reach the call light. R34 attempted to locate the call light on the bed and was unable. R34 was queried how they would obtain assistance if needed and R34 revealed she would yell out for staff.</p> <p>8/15/2024 at 8:21 AM, R34 revealed they had completed breakfast and was going to nap. R34's call light was within reach, lying on the bed.</p> <p>On 8/15/2024 at 9:24 AM, the Director of Nursing (DON) was interviewed regarding call light placement. The DON confirmed R11, R13, and R34 were all capable of using their call lights. The DON revealed the expectation is resident call lights should be within resident reach. The DON further revealed R11 and R13 tend to yell when they wanted anything.</p> <p>On 8/15/2024 the Restorative Nurse B was queried regarding R11, R13, and R34's ability to effectively use the call light. They indicated R11, R13, and R34 have the physical ability to activate the call light.</p> <p>The policy , Call Light Accessibility and Timely Response, dated 8/16/2023 under Guidance, revealed Staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed.</p>		