STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235613	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Rehab Center	3999 Venoy Road Wayne, MI 48184

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45038 Based on observation, interview, and record review the facility failed to assess for self-medication administration prior to leaving medications at bedside for one resident (R12) out of two residents reviewed during medication administration. Findings Included: Resident #12(R12) Review of the medical record demonstrated R12 was admitted to the facility 06/25/2023 with diagnoses that included congestive heart failure, hypertension, cardiomyopathy (disease of the heart muscle that makes it hard for the heart to pump blood), atrial fibrillation, venous insufficiency, chronic obstructive pulmonary disease (COPD), and Gout (build up of uric acid in bone joints). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/16/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During medication administration on 09/26/2024 at 07:30 a.m. Registered Nurse (RN) I was observed preparing medication to be given to R12. RN I explained that R12 had medication at beside that she administered on her own. RN I explained Magnesium 400mg (milligrams) one tablet once per day was the order for the medication that the resident provided on her own. On 09/26/2024 at 07:38 a.m. R12 was observed lying in bed. Registered Nurse (RN) I asked R12 if she wanted to have her Lidocaine Patch 4% Topically applied now and R12 responded to leave it on the nightstand, and she would place it on herself later. RN I was observed to leave the Lidocaine Patch 4% topically at R12's nightstand. RN I then asked if R12 had her Magnesium 400 mg(milligrams) one tablet once per day. R12 demonstrated a bottle of Magnesium 200mg tablets and R12 explained that she took two tablets because she was ordered 400mg one tablet once per day. RN I asked R12 if she would like her breathing treatment of Ipratropium-albuterol solution for nebulization 0.5mg-3mg (2.5mg base/3ml(milliliters); amt (amount): 1 vial inhalation currently. R12 explained that she would like the vial left on the nightstand and she would administer the breathing treatment to herself after breakfast. RN I left the breathing treatment on the nightstand and left the room. On 09/26/2024 at 07:45 a.m. Registered Nurse (RN) was asked if R12 had an order to self-administer medication and an order to leave medication as R12's bedside. RN I responded yes. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R12's medical record did not demonstrate that a physician's order was present to self-administer any medication and did not demonstrate a physician's order to keep medication at her bedside. Review of R12's plan of care did not demonstrate any information on R12's capacity to self-administer medication or was able to have certain medications at her bedside. Review of R12's medical record demonstrated a Evaluation for Self-Administration of Medication, dated 09/07/2023, which revealed R12's preference was to documented as I prefer to utilize the facility's nursing services and the section of self-administration of medication was left blank. During an interview on 09:26/2024 at 09:00 a.m. Interim-Director of Nursing (DON) explained that residents must be evaluated for self-administration of medication and must have a physician order for self-administration of medication. Interim DON also explained that if medication was to be left at a resident's bedside the facility would supply a lock box for the resident to keep the medication at bedside. Interim- DON confirmed that the Evaluation for Self-Administration of Medication, dated 09/07/2023, demonstrated that R12 did not want to administer her own medication. Interim-DON could not provide another Evaluation for Self-Administration of Medication that had been completed for R12 demonstrating that she was capable or desired to administer her own medication. Interim-DON could not demonstrate that R12 had a physician's order to self-administer medication.

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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** 47964 Based on observation, interview, and record review, the facility failed to 1. Properly secure protected health information for one resident (R29) out of one resident reviewed for privacy of medical information, resulting in the potential for unauthorized disclosure, access and modification 2. Provide a privacy curtain for one resident (R8) out of one resident reviewed for privacy resulting in resident dissatisfaction and a lack of privacy. Findings include: R29 On 9/25/24 at 3:46 PM a hallway facility computer screen was observed unlocked. The electronic health record (EHR) for Resident R29 was visible. Personal, identifiable information for R29 was observed accessible to multiple staff and visitors in the common area of the hallway. Certified Nursing Assistant (CNA) D was designated as logged into the unlocked computer. Upon returning to the computer screen CNA D was interviewed and said she walked away from the screen to answer a call and did not log out or close the screen. CNA D stated I should have logged off. On 9/27/24 at 11:00 AM the Director of Nursing (DON) was interviewed and said if a staff member walks away from a EHR screen they should log out or close the screen to protect confidential patient information. R8 On 9/25/24 at 10:47 AM R8 was interviewed and stated I don't have a privacy curtain. I should have one. My other two roommates have one. Where's my privacy? R8's bed did not have a bed curtain. When asked if there was previously a bed privacy curtain R8 replied Yes, but I don't know what happened to it. On 9/25/24 at 4:15 PM there was no bed curtain observed for R8's bed. On 9/26/24 at 8:23 AM there was no bed curtain observed for R8's bed. On 09/26/24 at 10:33 AM Maintenance Director (MD) E was interviewed and said he got a work order for R8's privacy curtain two weeks ago. He removed the entire privacy curtain bracket but hasn't had a chance to reinstall due to a lack of maintenance staff to help. I usually would have that done within a couple of days. MD E agreed R8's bed should have a privacy curtain and the replacement was not timely. Record review of R8's electronic health record revealed admission to the facility on [DATE] with diagnosis that included type 2 diabetes mellites, difficulty in walking and muscle weakness. The Minimum Data Set (MDS) dated [DATE] indicated R8 had moderately impaired cognition with a BIMS (brief interview for mental status) score of 10/15. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the maintenance request dated 9/12/24 revealed cracked holder for privacy curtain rod. Needs to be replaced and put-up tracking and hang curtain. Comments pending took curtain rail down will install next week by 9/19/24. On 9/27/24 at 11:00 AM the DON was interviewed and agreed each resident bed should have privacy curtain to maintain resident privacy. Review of the facility policy titled Confidentiality of Personal and Medical Records revised May 2024 revealed in part . This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45038 Based on observation, interview, and record review the facility failed to provide Activities of Daily Living (ADL's), including bathing/showering/shaving for one dependent resident (R1) out of two residents reviewed of ADL completion. Findings Included: Resident #1 (R1) Review of the medial record demonstrated R1 was admitted to the facility 06/27/2018 with diagnoses that included athetoid cerebral palsy (a movement disorder that causes involuntary muscle movements), hypertension, peripheral vascular disease (PVD) hyperlipidemia (high fat levels in the blood), abnormalities of gait and mobility, muscle weakness, and major depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 09/25/2024 at 01:31 p.m. R1 was observed lying in bed with facial hair stubble that appeared had not been shaved in several days. R1 explained that he would like to be shaved but the staff have not assisted him awhile. R1 explained that the staff only seem to shave him when they feel like it. R1 could not explain that last time that he was shaved. During observation on 09/26/2024 at 10:09 a.m. R1 was observed lying in bed with facial hair stubble that appeared longer than the previous observation. R1 appeared to be sleeping at time of observation In an interview on 09/26/2024 at 10:10 a.m. Certified Nursing Aide (CNA) B explained that she was caring for R1 at this time. CNA B explained that residents were to be shaved on the day of their showers. CNA B explained that the facility used a shower sheet that was kept at the nurse's station. CNA B explained that R1 was to be showered on Monday and Thursday during the night shift. CNA B' reviewed the notebook containing R1's shower sheets and demonstrated shower sheets for the dates of 9/16/2024 (shaving was not checked off), 09/19/2024 (shower refused) and 09/23/2024 (shaving was not check off). In an interview on 09/26/2024 at 10:25 a.m. Interim-Director of Nursing (DON) explained that residents at the facility received showers/baths twice per week. Interim-DON explained that it is the expectation, with male residents, that they are shaved on the same day as the showers/baths. Interim-DON explained that shaving would be documented on the shower sheets of that Resident. Interim-DON confirmed that R1's shower sheets for 09/16/2024 did not have documentation of shaving, and confirmed R1's shower was refused on 09/19/2024, and confirmed R1's shower sheet for 09/23/2024 did not have documentation for shaving. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 09/26/2024 at 10:38 a.m. Interim-Director of Nursing (DON) observed, with this surveyor, that R1 was lying down in bed and appeared to be sleeping. R1 was also observed with facial stubble. Interim-DON explained that R1 should have been shaved last night. Interim-DON could not explain why R1 was not shaved last night at his shower time. Interim-DON could not produce a shower sheet from last nights scheduled shower.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on observation, interview, and record review, the facility failed to remove expired, undated, unlabeled food from the kitchen walk-in cooler, freezer, pantry and resident refrigerators. This deficient practice had the potential to affect all the residents who consumed food from the kitchen and resident refridgerators, resulting in the increased potential for food borne illness. Findings include: On [DATE] beginning at 8:45 AM, the initial tour of the kitchen was conducted with Dietary Manager (DM) A. During the tour, the following items were observed in the walk-in cooler: - a box of opened moldy bell peppers undated - two bags of mixed salad rotten undated. - a tub of white onions undated - a box of single serving sour cream undated no expiration date The following item was observed in the kitchen freezer: -a frozen 20-ounce bottle of red pop. DM A said staff items do not belong in this fridge/freezer. The following was observed in the pantry: - an opened 26-ounce bottle of honey with expiration date of [DATE]. DM A agreed all items should be labeled, dated and expired items thrown away. On [DATE] at 9:55 AM the North unit resident refrigerator/freezer was observed with Certified Nursing Assistant (CNA) B. The following items were observed: - one 'to go' container unlabeled undated. CNA B stated That's' my lunch. I know it doesn't belong in the resident fridge. -one opened bottle of tea unlabeled, no open date. -one container of cream cheese, unlabeled. -one opened bottle labeled ginger no open date, no expiration date. -one opened bottle of chili sauce unlabeled, no open date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-one opened bottle of banana sauce unlabeled, no open date. -one opened 16-ounce bottle of water unlabeled, no open date. -one opened bottle of spring roll sauce unlabeled no open date. -one opened bottle of flavored water unlabeled, no open date. -one 66 ounce opened bottle of coffee mate unlabeled no open date. -one box of pizza unlabeled, no open date. Freezer -one frozen meal unlabeled. -one frozen milk unlabeled with sell by date of [DATE], expired. -four frozen yogurts unlabeled with use by date of [DATE] expired. On [DATE] at 10:15 AM the South unit resident refrigerator/freezer was observed with Registered Nurse (RN) C. The following items were observed: -one opened two liter of coke unlabeled no open date. -one opened two liter of mountain dew unlabeled no open date. -one rotted orange - one opened box of thickened honey unlabeled open date of [DATE] use by date [DATE] expired. -one opened bottle of ketchup unlabeled no open date. -one opened bottle of grape jelly unlabeled no open date. -one piece of fried chicken labeled with date of [DATE] expired. RN C agreed items should be labeled, expired rotten food thrown out and staff food does not belong in the resident refridgerator. On [DATE] at 11:05 AM the Nursing Home Administrator (NHA) and Director of Nursing (DON) were interviewed and said they are unsure which department was responsible to maintain the unit refrigerators. Both the NHA and DON agreed staff food does not belong in the unit refrigerators, items should be dated, labeled and expired/rotten food should be removed to prevent resident food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled (Facility Name) Rehab and Neuro Center Food Safety Requirements revealed in part . Food will be stored, prepared and served in accordance with professional standards for food service safety. Labelling, dating and monitoring refrigerated food, so it is used by its use-by date. Review of the facility policy titled Use and Storage of Food Brought in by Family or visitors revealed in part . All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. The prepared food must be consumed by the resident with in 3 days. If not consumed within 3 days, food will be thrown away by facility staff.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 45038 Based on observation, interview, and record review the facility failed to coordinate hospice services for one resident (R9) out of one resident reviewed for coordination of hospice services resulting in the potential for care not being provided to resident receiving hospice services and the potential for residents not to be fully informed of hospice services provided. Findings Included: Resident #9 (R9) Review of the medical record demonstrated R9 was admitted to the facility 07/09/2024 with diagnoses that included benign neoplasm (tumor that does not invade neighboring tissue or metastasize) of left kidney, type 2 diabetes, abnormal weight loss, pain, repeated falls, hyperlipidemia (high fat content in blood), hyponatremia (low sodium levels in blood), hypertension, chronic obstructive pulmonary disease (COPD), osteoarthritis (chronic disease that causes breakdown in cartilage), gout (high uric acid levels), hemiplegia (condition that cause partial or complete paralysis) affecting right side. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/13/24, demonstrated a Brief Interview for Mental Status (BIMS) of 13 (cognitively intact) out of 15. During observation and interview on 09/25/2024 at 09:34 a.m. R9 was observed lying in bed. R9 explained that he currently received Hospice Services. R9 could not explain what disciplines provided services to him or the frequency that those Hospice disciplines provided that care. R9 denied bring provided a calendar of Hospice Services that were to be provided. No Hospice Service calendar was visible in R9's room. Review of R9's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/13/24, Section O- Special Treatments, Procedures, and Programs demonstrated that R9 was receiving Hospice Services at the facility. Review of R9's physician's orders demonstrated an order written 07/10/2024 which stated On Hospice- (name and telephone number of agency). Review of R9's plan of care demonstrated the problem statement, with the implementation date of 07/17/2024, which stated ADLs Functional Status/Rehabilitation Potential- I require hospice services R/T(related to) renal mass. The plan of care did not demonstrate the frequency or the schedule of Hospice Services to be provided. The plan of care did not demonstrate which Hospice Services were to be provided. In an interview on 09/25/2024 at 04:07 p.m. Registered Nurse (RN) K explained that residents that received Hospice Services would have a physician order, and all Hospice information would be located in the Hospice Notebook at the Nurse's Station that would have a calendar of when Hospice Visit were to occur and what Hospice services were to be provided. RN K demonstrated R9's Hospice Notebook. Review of R9's Hospice Notebook contained a blank Hospice Calendar and failed to demonstrate which Hospice Services were to be provided and when those services were to be provided. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/25/2024 at 04:13 p.m. Interim-Director of Nursing (DON) explained that it was the expectation that a Hospice Calendar be placed in a Resident's Hospice Notebook which would demonstrate what and when Hospice Services where to be provided. Interim-DON also explained that is the expectation that the residents plan of care list what Hospice Services were to be provided and when those Hospice Services were to be provided. Interim-DON was given R9's Hospice Notebook and asked to demonstrate a current Hospice Calander. Interim-DON confirmed that no current Hospice Calendar was in R'9s Hospice Notebook. Interim-DON also confirmed that the R9's Hospice care plan did not list Hospice Disciplines or frequency of those visits. Interim-DON explained that it was her opinion that R'9s Hospice Care Plan was not complete. Interim-DON was asked to provide documentation of care conference collaboration with Hospice Services. Interim-DON could not demonstrate documentation of any care conference or any meeting that had occurred with the involvement of Hospice Services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 34901 Based on interview and record review, the facility failed to establish a comprehensive Infection Control Program that conducted proper facility-wide surveillance and consistently reviewed microbiology summary reports. Findings include: On 9/27/24 beginning at 11:35 AM, the facility's infection control program was reviewed with Infection Preventionist (IP) F and the Interim Director of Nursing (I-DON) and the following was noted: 1. When queried about a list of diseases that may occur that are to be reported to state and local health departments, IP F stated, I don't have a list. 2. When queried about a staff call-in log that documents staff's reasons for calling in, IP F stated, I don't look at the nurse call-in log. IP F added that sometimes the nurse will inform her if the employee calls in sick with symptoms, but this information is not documented or tracked. The I-DON said staff call-ins should be tracked so we know if there is an infection brewing or starting. This information can be used to monitor the residents that the staff have taken care of. 3. The microbiology summary report from the laboratory was requested but was not available. The Incoming Director of Nursing was present and stated the summary report included the results of the cultures completed for the month with cross references of the antibiotic usage for the month. The report helps to prevent overuse or inappropriate use of antibiotics. A review of the policy titled, Antibiotic Stewardship Program, dated June 2024, documented in part the following: - The consultant laboratory will create a summary report of antibiotic susceptibility patterns from organisms isolated in cultures. A review of the policy titled, Infection Surveillance, dated June 2024, documented in part the following: - Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks. - Data to be used in the surveillance activities may include, but are not limited to: Staff reports of signs and symptoms and other relevant documentation, if indicated. On 9/27/24 at 3:30 PM during the exit conference, Medical Director G was unable to provide documentation to support that the laboratory microbiology summary report was received and discussed during the infection control meetings.