STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235619	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 This citation pertains to Intake M100143631. Based on interview and record review, the facility failed to honor the advance directive/code status wishes for one (R707) of four resident's reviewed for advance directives. Findings include: Review of the facility record for R707 revealed an admitted [DATE] with diagnoses that included Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, and Heart Failure. Review of R707's progress note dated [DATE] and authored by Licensed Practical Nurse (LPN) B indicated cardio-pulmonary resuscitation (CPR) had been initiated at 8:25 AM on [DATE] and following arrival of emergency medical staff, CPR was discontinued and the time of death was recorded as 8:31 AM. Review of R707's physician orders revealed a Do Not Resuscitate (DNR) order dated [DATE], a renewed DNR order dated [DATE]. Further review of the physician's orders revealed an order documenting Full Code dated [DATE]. The record indicated that R707 signed on to hospice services on [DATE]. Review of the Advance Directive document in the facility record for R707 revealed a DNR status dated [DATE]. The document was signed by FM C and by two facility staff members as witnesses. The document was not signed by the physician. On [DATE] at 2:44 PM, R707's family member/Responsible party (FM) C was interviewed by phone. FM C reported that R707 had been transferred to hospice service the day prior ([DATE]) to their passing. They reported their understanding was that R707 had DNR status during the entirety of their stay at the facility or at least for an extended period and that it remained in place at the time of their passing. FM C reported that they were not aware that R707 received CPR and it was their understanding R707 would not receive CPR. FM C reported if R707 did receive CPR they would find it troubling and they felt it should be addressed so it doesn't happen to someone else. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Church of Christ Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23575 15 Mile Rd Clinton Township, MI 48035	

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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:50 PM, LPN B was interviewed via phone call. LPN B reported they did recall the morning that R707 expired and reported they were present in R707's room when a code was called and CPR was administered. LPN B reported R707 had been found unresponsive however there was confusion because it was believed the family had signed a DNR but that it hadn't been signed by the doctor yet so it was believed we had to call a code and do CPR. LPN B reported they did not know how much time elapsed between R707 being found unresponsive and CPR being initiated because they arrived for their shift after the situation was already occurring. On [DATE] at 3:40 PM, the facility Director of Nursing (DON) was asked why R707's code status in the physician orders had changed between [DATE] and [DATE] when R707 had been in DNR status for an extended period and the only available Advance Directive document indicated DNR status. The DON reported R707's code status was changed to full code because the facilities Quality Assurance (QA) audits completed by the [NAME] President of Clinical Operations (VPCO) determined that the existing DNR forms being used in the facility were not in compliance with State regulations and required transition to State compliant forms. The DON reported during this transition R707's code status had to be changed to full code until the proper forms were in place. On [DATE] at 4:05 PM, the facility Administrator (NHA) reported they were aware of the situation involving R707's code status change and they reported R707's responsible party had been notified of the resident's change in code status. Documentation of the communication to the responsible party was requested however none was received by the time of survey exit/completion. On [DATE] at 4:25 PM, The VPCO was interviewed and reported the Advance Directive form that indicated DNR status for R707 that was signed by FM C and facility witnesses on [DATE] was the updated and proper form but that it had not been signed by the physician which is what prompted the change to full code status in the physician orders. The VPCO acknowledged the form had gone unsigned by the physician since [DATE] and the lack of a physician signature was noted upon R707's transfer to hospice service which prompted the change to full code status and led to R707 receiving CPR. Review of the facility policy Residents' Rights Regarding Treatment and Advance Directives dated ,d+[DATE] revealed the Policy statement It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. The Policy Explanation and Compliance Guidelines portion includes the entries: .5. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate .6. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

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)

F 0689

Level of Harm - 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 46956

This citation pertains to intake M100144181.

Based on observation, interview and record review, the facility failed to implement measures to prevent multiple falls for one (R701) of eight residents reviewed for falls, resulting in a right femur fracture that required a surgical repair, additional assistance with transfers and pain management. Findings include:

Review of the facility record for R701 revealed an admitted [DATE] with diagnoses that included Alzheimer's Disease, Diabetes Mellitus, and Difficulty in Walking. The Minimum Data Set (MDS) assessment dated [DATE] included a Brief Mental Status (BIMS) score of 03/15 indicating Severe Cognitive Impairment. Review of R701's admission Fall Risk Evaluation dated 05/19/23 revealed a score of 10 (evaluation instructions state If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan.)

On 05/01/24 at 11:45 PM, R701 was observed sitting in their wheelchair in their room. R701 responded verbally to the surveyor but was not able to answer questions in a reliable manner.

Further review of R701's record revealed an initial fall on 05/26/23 (one week after admission). Review of R701's care plan history indicated that a fall prevention care plan focus and interventions were not established until 05/30/23. The care plan intervention initiated on 05/30/23 stated Monitor/document/report PRN (as needed) x 72h (every 72 hours) to MD (physician) for s/sx (signs/symptoms): Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation.

R701's next fall occurred on 09/06/23. Review of the care plan history revealed no new fall prevention interventions were added in response to this fall.

R701's next fall occurred on 09/12/23. On 09/13/23 the following interventions were added: 1. Provide activities that promote exercise and strength building where possible. 2. PT (Physical Therapy) consult for strength and mobility.

R701's next fall occurred on 10/04/23 and no new fall prevention interventions were added to the care plan in response.

R701's next fall occurred on 11/18/23. No new fall prevention interventions were added to the care plan in response.

R701's 11/19/23 progress note indicated that the resident was expressing signs/symptoms of pain and X-ray results on 11/20/23 revealed R701 sustained a right femur/hip fracture. R701 was discharged to hospital for surgical repair of the right hip.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

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)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

R701 was readmitted to the facility on [DATE]. The new admission Fall Risk Evaluation was scored 9 (lower risk score than at original admission). The evaluation question History of falls (past 3 months) was answered B. 1-2 falls in past 3 months. R701 actually had four falls in the prior three months. Review of the care plan established upon readmission revealed the same three fall prevention interventions that were previously in place were renewed and no new interventions were recommended or added.

R701's next fall occurred on 12/24/23. No new fall risk care plan interventions were added in response.

Further review of R701's care plan history indicated per the transfer safety focus area that R701 required hand-held assist for transfers at admission and at readmission following the fall with right femur fracture Maximum (approximately 75% of workload) assistance for transfers was required. R701's 11/28/23 readmission progress note indicated that the resident required a right hip surgical site pain pump.

On 05/02/24 at 3:30 PM, the facility Director of Nursing (DON) acknowledged that the fall prevention care plan had not been established until after R701's first fall rather than following the admission Fall Risk Evaluation indicating High Risk. The DON acknowledged that new interventions had not been added to the fall prevention care plan after four of six falls but indicated that their understanding was that there was also a safety focus area in the care plan that may have fall interventions added. Review of the Safety focus area in R701's care plan revealed no fall prevention interventions. When asked what their expectation was regarding revision of the care plan following repeated falls the DON reported that it would be their preference that new interventions be added in the fall prevention focus area.

Review of the facility policy Fall Prevention Program dated 02/05/22 revealed the Policy statement Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The Policy Explanation and Compliance Guidelines section includes the following entries:

1. The facility utilizes a standardized risk assessment for determining a resident's fall risk.

a. The risk assessment categorizes residents according to low, moderate, or high risk.

2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk.

3. The nurse will indicate on the FALL COMS the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk.

4. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions.

6. High Risk Protocols:

a. The resident will be placed on the facility's Fall Prevention Program.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Church of Christ Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23575 15 Mile Rd Clinton Township, MI 48035	

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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	i. Indicate fall risk on care plan. b. Implement interventions from Low/Moderate Risk Protocols. c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. d. Provide additional interventions as directed by the resident's assessment, including but not limited to: i. Assistive devices ii. Increased frequency of rounds iii. Sitter, if indicated iv. Medication regimen review v. Low bed vi. Alternate call system access vii. Scheduled ambulation or toileting assistance viii. Family/caregiver or resident education ix. Therapy services referral 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	g. Obtain witness statements in the case of injury.