

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/02/2024
NAME OF PROVIDER OR SUPPLIER  Laurels of Carson City		STREET ADDRESS, CITY, STATE, ZIP CODE  620 North Second Street Carson City, MI 48811	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45410</p> <p>This Citation pertains to Intake Number MI00145232.</p> <p>Based on interview and record review the facility failed to ensure adequate assessment and monitoring of a resident having chest pain and using nitroglycerin for one resident (Resident #101) of 3 residents reviewed for change of condition, resulting in incomplete information being communicated to the medical practitioner, the potential for unnoticed cardiovascular compromise, and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>Resident #101:</p> <p>Review of an Admission Record revealed Resident #101 admitted to the facility on [DATE] with pertinent diagnoses which included congestive heart failure and hypertensive heart (complications of high blood pressure that affect the heart).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 6/15/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #101 was cognitively intact.</p> <p>Review of risk for pain Care Plan interventions for Resident #101, initiated 6/11/2024, directed staff to anticipate resident's need for pain relief as needed, respond immediately to any complaint of pain, and notify the physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/1/2024 at 11:06 AM, Family Member L reported she received a phone call from Resident #101 on 6/14/2024 at 9:30 PM and Resident #101 was distraught because he was having chest pains. Family Member L reported a nurse came into the room and demanded Resident #101 to give the bottle of nitroglycerin to her. Family Member L reported they told the nurse Resident #101 needed to keep the nitroglycerin and that he was having chest pain. Family Member L reported the nurse was focused on removing the bottle of nitroglycerin from Resident #101's room and never took his vital signs or assessed him for his symptoms of chest pain. Family Member L reported she stayed on the phone with Resident #101 from 9:30 PM until she arrived at the facility at approximately 00:13 AM. Family Member L reported the nurse did not return to Resident #101's room from 9:30 PM until she returned to administer medication at approximately 11:00 PM. Family Member Y reported Resident #101 took 3 nitroglycerin tablets in this timeframe and continued to notify staff by pressing his call light with each dose of nitroglycerin. Family Member Y reported the nurse kept sending the Certified Nursing Assistant (CNA) into the room when Resident #101 pressed his call light. Family Member Y reported the nurse never attempted to assess Resident #101 or take his vital signs from 9:30 PM until family removed him from the facility at approximately 00:30 AM. Family member Y reported Resident #101 appeared pale and upset when family arrived at the facility.</p> <p>Review of Resident #101's Nurses Notes, dated 6/15/2024 at 8:41 AM, documented by Licensed Practical Nurse (LPN) B, revealed .2000 hrs. while administering meds, this nurse noted that the resident had Nitroglycerin in a bottle, sitting on his overbed table. I stated that I needed to have them to place locked up in the nurses cart. Resident refused. He stated that because he is on Hospice he can do what he wants. His son was on the cell phone. Phoned on call ADON who listened as I explained that this is serious and that he can't just take them whenever. I was informed by management that I cannot force the resident to give up the little bottle. Phoned on call physician. Was told that I need hospice to talk with him. Phoned (Hospice company) to inform of situation. Hospice nurse said she would educate family and (patient). Next the (certified nursing assistant) working reported that the resident had taken a fourth pill. I approached resident and explained that 1) the medicine should only be administered while having chest pain per protocol 2) it shall remain on nurses cart. Family arrived and gathered belongings and resident and left without taking any medications with them and refused to sign discharge paperwork .</p> <p>Review of Resident #101's Physician's Orders on 7/1/2024 at 10:30 AM revealed Resident #101 had an order for Nitroglycerin Sublingual Tablets 0.4 mg during his stay, with a start date of 6/10/2024, and instructions to give 1 tablet sublingually every 5 minutes as needed for Angina (chest pain) with a maximum of 3 doses. Further review of Resident #101's Electronic Medical Record (EMR) revealed no further documentation by LPN B of vital signs the evening of 6/14/2024 and no attempted assessment of Resident #101's chest pain or re-evaluation after taking doses of nitroglycerin.</p> <p>In an interview on 7/1/2024 at 12:54 PM, CNA I reported he was caring for Resident #101 the evening of 6/14/2024. CNA I reported at some point that evening Resident #101 pressed his call light and complained of chest pain while his family was on speaker phone. CNA I reported he notified LPN B that Resident #101 was having chest pain. CNA I reported Resident #101 had been taking nitroglycerin from a bottle he had in his room and LPN B had attempted to remove the bottle of nitroglycerin from the room, upsetting Resident #101 and the family who were on the speaker phone. CNA I reported family arrived and removed Resident #101 from the facility that evening.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/1/2024 at 2:48 PM, LPN B reported during medication pass the evening of 6/14/2024 Resident #101 reported to her that he was having chest pains and was going to take a nitroglycerin tablet. LPN B reported she observed a nitroglycerin bottle in his possession and explained that this needed to be stored in the medication cart. LPN B reported she had not witnessed Resident #101 take nitroglycerin tablets, but he reported taking multiple doses that evening to relieve his chest pain. LPN B reported resident did not seem like he wanted her near him and so she did not assess him or get his vital signs.</p> <p>In an interview on 7/2/2024 at 9:46 AM, Assistant Director of Nursing (ADON) C reported she received a call from LPN B the evening of 6/14/2024 regarding Resident #101's chest pain and the bottle of nitroglycerin in his room. ADON C reported she instructed LPN B to check vital signs every hour as they were not exactly sure when Resident #101 was taking nitroglycerin. ADON C reviewed Resident #101's EMR and could not find any vitals signs, assessments, or assessment refusals documented by LPN B the evening of 6/14/2024.</p> <p>In in interview on 7/2/2024 at 1:35 PM, Registered Nurse (RN) A reported she was working on the other side of the building the evening of 6/14/2024 when LPN B notified her that she found a bottle of nitroglycerin in Resident #101's room. RN A reported she was not aware Resident #101 was complaining of chest pain or that he was taking doses of nitroglycerin. RN A reported resident complaints of chest pain require prompt evaluation by nursing staff including vital signs regardless of whether the resident has a history of chest pain. RN A reported she would evaluate a resident after each dose of nitroglycerin, including vital signs.</p> <p>In in interview on 7/2/2024 at 2:47 PM, Nurse Practitioner K reported she received a call from nursing staff the evening of 6/14/2024 regarding a bottle of nitroglycerin found in Resident #101's room. Nurse Practitioner K reported she was not notified Resident #101 had chest pain or was taking doses of nitroglycerin.</p> <p>In an interview on 7/2/2024 at 11:50 AM, the DON reported residents complaining of chest pain should be promptly evaluated by nursing staff, including vital signs. The DON reported nursing staff should pause medication lines if necessary to ensure prompt evaluation of complaints such as chest pain. The DON reported nursing staff are expected to check vital signs 5 minutes after doses of nitroglycerin are administered. The DON reported nursing staff should document any refused assessments in the EMR.</p> <p>Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, The presence of chest pain requires an immediate thorough assessment, including location, duration, radiation, and frequency. In addition, it is important to note any other symptoms associated with chest pain, such as nausea, diaphoresis, extreme fatigue, or weakness. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 922). Elsevier Health Sciences. Kindle Edition.</p>		