

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER The Timbers of Cass County		STREET ADDRESS, CITY, STATE, ZIP CODE 55432 Colby St Dowagiac, MI 49047	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47955</p> <p>This citation pertains to intake MI00143214</p> <p>Based on interview and record review, the facility failed to report timely and accurately to the State Agency a required reportable incident of resident to resident abuse in 2 (Resident #104 and Resident #105) of 3 residents reviewed for reportable incidents resulting in the potential for additional reportable incidents go unreported and/or cause a delay in the investigative process.</p> <p>Findings include:</p> <p>Resident #104</p> <p>Review of a Face sheet revealed Resident #104 had pertinent diagnoses which included: Alzheimer's disease and vascular dementia with behavioral disturbances.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 3/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #104 was severely cognitively impaired.</p> <p>Review of Progress Notes for Resident #104 dated 2/28/24 at 7:51 PM., revealed .an incident occurred between Resident #104 and Resident #105 while sitting at the nurse's station, residents were separated, family (daughter) notified</p> <p>Review of Incident Report revealed .type of alleged incident . abuse .date/time of incident discovered 2/28/24 6:50 PM . date/time incident occurred 2/28/24 6:50 PM . incident submission . submitted by Nursing Home Administrator (NHA) A . submitted date/time 2/29/24 8:57 AM .</p> <p>Resident #105</p> <p>Review of a Face sheet revealed Resident #105 had pertinent diagnoses which included: unspecified dementia, without behavioral disturbance, psychotic disturbance, and anxiety.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 5/4/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #105 was severely cognitively impaired.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Progress Notes for Resident #105 dated 2/28/24 9:31 PM., revealed .was in a confrontation with Resident #104. It ended with a skin tear on the backside of this residents left hand approx. 1/2 cm and on the palm of this residents hand approx. 1/2 cm .administrator notified, Dr. notified, family notified, corporate nurse notified, and the police were notified and a report taken .</p> <p>Review of Incident Report revealed Resident #105 was named as a resident in the incident .was harmed yes . type of injury/harm: Physical . alleged incident . abuse .date/time of incident discovered 2/28/24 6:50 PM . date/time incident occurred 2/28/24 6:50 PM . incident submission . submitted by NHA A . submitted date/time 2/29/24 8:57 AM .</p> <p>Review of facility policy Abuse Prevention Program 7 Components with a revision date of 1/2024 revealed . all alleged or suspected violation are to be reported immediately to the administrator or Director of Nursing which are responsible to notify required officials, including to the State Survey Agency .all alleged violation involving abuse .are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse . A resident-to-resident altercation should be reviewed as a potential situation of abuse .</p> <p>In an interview on 6/21/24 at 10:54 AM., NHA A reported that he did not recall a delay in reporting the resident-to-resident incident with Resident #104 and Resident #105 from 2/28/24. NHA reported that when he was reporting the resident-to-resident incident between Resident #104 and Resident #105 he was using his new laptop computer, from home, and it was the first time he tried to access the State Agency reporting website from that computer. NHA A reported that it was getting late when he tried to submit the report to the State Agency and for some reason it did not go through. NHA A reported that he is required to report allegation of abuse to the State Agency within 2 hours. NHA A reported that he did submit this report to the State Agency the following day after the alleged incident occurred. There was no discussion as to why only the NHA was responsible for reporting incidents although the reporting system allows for up to 6 reporters if needed.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47955</p> <p>Based on observation, interview, and record review the facility failed to ensure safe transport of a resident in a wheelchair with foot pedals was in place in 1 (Resident #106) of 1 resident reviewed for accidents resulting in the potential for injury to the resident.</p> <p>Findings include:</p> <p>Review of an Face sheet revealed Resident #106 had pertinent diagnoses which included: Visual loss, both eyes, muscle weakness, and legal blindness, as defined in USA.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 6/2/24 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #106 was moderately cognitively impaired.</p> <p>On 6/18/24 at 10:15 AM., Resident #106 was observed being pushed in his wheelchair in the 100 hall and the hallway to the activities room by Activities Aide (AA) I. Resident #106 did not have footrests in place on his wheelchair. Resident #106 was wearing slippers, and his feet were crossed at the ankles and elevated off the floor. AA I was heard saying to Resident #106 Do you have your feet up? Resident #106 was heard saying Yes.</p> <p>During an interview on 6/18/24 at 10:59 AM., AA I reported she was pushing Resident #106 from his room to the activities room without footrests on his wheelchair. AA I reported that he should have had footrests on his wheelchair to be pushed.</p> <p>On 6/18/24 at 1:51 PM., Resident #106 was observed being pushed in his wheelchair without footrests in place on his wheelchair in the 100 hall and the hallway to the dining room by AA I. Resident #106's feet were crossed at the ankles, and he was holding his feet off the floor.</p> <p>On 6/18/24 at 3:14 PM., Resident #106 was observed being pushed in his wheelchair without footrests in place on his wheelchair in the hallway by the dining room by Activities Director (AD) H. AD H stated to this surveyor as she walked by I know, he needs his foot things and this surveyor watched as AD H continued to push Resident #106 through the hallway.</p> <p>In an interview on 6/18/24 at 3:17 PM., AA I reported that she did push Resident #106 to an activity before 2:00 pm today without his footrests on his wheelchair. AA I reported that she looked for Resident #106's wheelchair footrests and the one she found did not fit his wheelchair. AA I reported that Resident #106 has no footrests on his wheelchair listed in his care plan.</p> <p>In an interview on 6/18/24 at 3:21 PM., AD H reported residents were required to have footrests on their wheelchairs if they were being pushed by staff. AD H was asked by this surveyor if she continued to push Resident #106 after she acknowledged that he needed his footrests on his wheelchair to this surveyor and AD H stated Yes, I took his to his room. AD H reported that Resident #106's preference was to not have footrests on his wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/20/24 at 11:25 AM., Certified Nurse Assistant (CNA) V reported that wheelchairs need to have footrests in place for residents if they are being pushed in the hallway. CNA V reported that residents that self-propel their wheelchair would not have footrests on their wheelchairs.</p> <p>In an interview on 6/20/24 at 11:28 AM., Registered Nurse (RN) BB reported that Resident #106 is blind and had to have his footrests on his wheelchair when his is being transported. RN BB reported that Resident #106 had to be pushed in his wheelchair, he does not self-propel since he cannot see where he is going.</p> <p>During an observation on 6/20/24 at 12:14 PM., Resident #106's wheelchair was present in his room, next to his bed, and one footrest, the left one, was in place on the wheelchair.</p> <p>In an interview on 6/20/24 at 2:20 PM., Director of Nursing (DON) B reported that he was currently re-educating all staff on the use of footrests on wheelchairs.</p> <p>Review of Care Plan for Resident #106 revealed, .Alteration in ALDs - self care deficit .uses WC (wheelchair) for mobility, started on 2/24/21, .visual function .severely impaired vision .assess the effect of vision loss on Resident's functional status .Transfer status 1 assist with a gait belt .</p> <p>Review of Care Guide for Resident #106 revealed .transport .WC, encourage resident to use foot .</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47955</p> <p>Based on observation, interview, and record review, the facility failed to: (1) properly store medications in a secure manner in 3 of 3 treatment carts reviewed and (2) ensure that treatment carts remained secure resulting in the potential for residents, visitors, and/or staff to access the medication in the facility with a current census of 104 residents.</p> <p>Findings include:</p> <p>Review of facility policy 5.3 Storage and Expiration Dating of Medications, Biologicals with a revision date of 8/7/23 revealed .3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors .</p> <p>In an observation on 6/18/24 at 10:30 AM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Birch nurse's station. Also noted on top of the treatment cart behind the Birch nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Birch nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an observation on 6/18/24 at 10:35 AM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Dogwood nurse's station. The treatment cart was noted behind the Birch nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an observation on 6/18/24 at 1:50 PM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Birch nurse's station. Also noted on top of the treatment cart behind the Birch nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Birch nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an observation on 6/18/24 at 2:16 PM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Dogwood nurse's station. The treatment cart was noted behind the Birch nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an observation on 6/18/24 at 4:07 PM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Evergreen nurse's station. Also noted on top of the treatment cart behind the Evergreen nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Evergreen nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 6/18/24 at 4:32 PM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Birch nurse's station. Also noted on top of the treatment cart behind the Birch nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Birch nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an observation on 6/20/24 at 9:00 AM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Dogwood nurse's station. Also noted on top of the treatment cart behind the Dogwood nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Dogwood nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an interview on 6/20/24 at 9:41 AM., Licensed Practical Nurse (LPN) Q reported that [NAME] Pain Gel was also known as biofreeze and was only given by physician order. LPN Q reported that it was a medication and was topically applied by only licensed nurses.</p> <p>In an observation on 6/20/24 at 10:02 AM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Evergreen nurse's station. Also noted on top of the treatment cart behind the Evergreen nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Evergreen nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an interview on 6/20/24 at 10:10 AM., LPN P reported that [NAME] Pain Gel was a medication, did require a physician order, and could only be applied topically by a nurse.</p> <p>In an observation on 6/20/24 at 12:17 PM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Dogwood nurse's station. Also noted on top of the treatment cart behind the Dogwood nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Dogwood nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>In an observation on 6/20/24 at 12:21 PM., a bottle with a pump top labeled [NAME] Pain Gel was noted on the top of the treatment cart behind the Evergreen nurse's station. Also noted on top of the treatment cart behind the Evergreen nurse's station was a basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels. The treatment cart was noted behind the Evergreen nurse's station and accessible to anyone on the unit, as no barrier was noted to prevent access.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and observation on 6/20/24 at 2:17 PM., Director of Nursing (DON) B reported that all medications should be locked in the carts. DON B reported that [NAME] Pain Gel was a medication and should be locked into the cart. DON B and this surveyor approached the medication cart that was at the Evergreen nurse's station and the medication cart was noted to be unlocked when DON B touched the front doors and lock. DON B stated to this surveyor that the bottle with a pump top labeled [NAME] Pain Gel and the basket with tubes and bottles of topical treatment creams and ointments with resident specific information on the labels that were out on top of the treatment cart should have been locked inside the cart and the cart should have been locked as well. LPN P, who was at the nurse's station at the time, said I'm taking care of it right now. LPN P then began removing the medication items from the top of the treatment cart at the Evergreen nurse's station.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47955</p> <p>Based on observation, interview, and record review the facility failed to ensure proper hand hygiene was performed during medication administration in 3 (Resident #107, Resident #108, Resident #109) of 3 residents reviewed for hand hygiene during medication administration, resulting in the potential for the spread of infection, cross-contamination, and disease transmission for residents who receive medication while residing in the facility.</p> <p>Findings include:</p> <p>Resident #10 & Resident #108</p> <p>During an observation on 6/20/24 at 9:17AM., Licensed Practical Nurse (LPN) Q prepared oral medications for Resident #108 at the medication cart outside of Resident #108's room. At 9:31 AM LPN Q entered Resident #108's room, used the vital sign machine to check Resident #108's blood pressure, then handed Resident #108 the cup of medications. Resident #108 took medications and requested a pain medication. At 9:36 AM., LPN Q exited Resident #108's room, retrieved a narcotic medication from the medication cart in the hallway, returned to Resident #108's bedside and administered the pain medication to Resident #108. At 9:40 AM., LPN Q returned to her medication cart in the hallway, used the computer mouse to document administration of Resident #108's medications.</p> <p>During an observation on 6/20/24 at 9:44 AM., LPN Q prepared medications for Resident #107 at the medication cart outside of Resident #107's room. At 9:53 AM., LPN Q entered Resident #107's room, applied gloves and checked Resident #107's blood sugar. (pierced the skin of a fingertip for a drop of blood to be applied to a test strip). LPN Q removed her gloves and handed Resident #107 the medication cup with pills in it. LPN Q returned to the medication cart in the hallway outside of Resident #107's room to prepare Resident #107's insulin injection. LPN Q then went to the medication room to retrieve more insulin for Resident #107. At 9:55 AM., LPN Q returned to the cart and drew into a syringe Resident #107's insulin dose. At 9:57 AM., LPN Q entered Resident 107's room, applied gloves, administered Resident #107's insulin injection, removed gloves and exited the room, returned to the medication cart. LPN Q when at the medication cart, was observed using the computer mouse, computer keyboard, keys to unlock cart, handling Resident #107's insulin vial out of the drawer and back into the drawer. LPN Q then applied gloves and retrieved a Sani-cloth disinfection wipe to cleanse the vial sign machine.</p> <p>At no time during the observation of medication administration for both Resident #108 and Resident #107 was LPN Q observed performing hand hygiene.</p> <p>In an interview on 6/20/24 at 10:25 AM., LPM Q reported that she should perform hand hygiene every other resident when she was not touching a resident during medication administration. LPN Q reported that hand hygiene should be done between each resident and when removing gloves. LPN Q reported that she is unable to use hand sanitizer and she cleanses her hands with the purple wipes/Sani-Cloths instead.</p> <p>(continued on next page)</p>

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