

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Stonegate Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Demille Road Lapeer, MI 48446	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348</p> <p>This Citation pertains to Intake Numbers MI00142107 and MI00144987.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents were treated in a respectful and dignified manner for two residents (Confidential Resident #1 and Confidential Resident #2), who wished to remain as a confidential group of residents, from a facility census of 71 residents, resulting in a fear of accidents occurring due to call lights not being answered timely or call lights being turned off without completing the nursing task required, and residents' verbalizations of feelings of a lack of dignity, belittlement and discontentment.</p> <p>Findings include:</p> <p>CR1 and CR2 wished to remain confidential residents.</p> <p>Confidential Resident #1 (CR1):</p> <p>On 9/19/24 at 9:45 AM, CR1 was interviewed. CR1 revealed that she heard a nurse aide tell a resident: I'm busy, and you have a brief on, then just go and I'll be back. When CR1 was asked what the aide meant, CR1 further explained that since she has a diaper, she can just go. CR1 further stated, It is not verbal abuse but can be a dignity issue. CR1 indicated that the resident's daughter was present when this happened and heard this. They are both here today. Other issues brought up by CR1 were:</p> <ol style="list-style-type: none"> 1. Lack of basic supplies:- Kleenex, Styrofoam cups, pull-ups <p>One lady four days without her size- had to use a bigger</p> <ol style="list-style-type: none"> 2. Not enough CNA- for example, during shower day <p>They only have one CNA to do their residents care and all the showers scheduled for the day. Sometimes done late in the day or skipped.</p> <ol style="list-style-type: none"> 3. The food is terrible. The food is not done, including Brussels sprouts and potatoes. No condiments were available. <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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Trays are passed at about 6:20 PM. Last night, CR1 claimed she ate dinner late at 7 PM because her potato was not ready. She was told to wait until all trays are passed before they can resolve her food issues.</p> <p>5. During shift change- the outgoing staff would sometimes say, I'm not doing that, I'm not doing this. Passing on the job to the next shift.</p> <p>Confidential Resident #2 (CR2):</p> <p>CR2, on 9/19/24 at noon, was with her daughter in the visiting area and was observed with oxygen per nasal cannula. She was comfortable and was found not in any form of cardio-respiratory distress. CR2 said she pulled up instead of using a diaper preference, but they used the pads at the facility because they don't absorb much. She stated, I always feel bad because I pee a lot, and it gets all the sheets wet, and I did not want to have them change the entire bed sheet. I feel embarrassed. CR2 denied recalling the aide's name, who told her to Go ahead and go there. They come in, turn the call light off, and then say they will get somebody to help them. Then they forget to come back. If the aides don't turn the call light off, sometimes they may not return.</p> <p>Another incident, according to CR2, was just recently. CR2 described that an aide had set her up on the sink and left. CR2 realized she didn't have her oxygen on her. It is always on her, and she felt she should have it at that moment. CR2 decided to get someone and peeked out of the hall. When the staff asked what she needed, she felt dismissed when she was told by staff, It's over there. CR2 stated that she could see the nasal cannula, but she could not get through it because of obstacles while she was in her wheelchair. She could not reach for the O2 tubing and put it on her nose. She felt she was treated without dignity and was disrespected. CR2 said she felt angry and degraded.</p> <p>During an interview with CR2's daughter, on 10/19/24 at 12:20 PM, the daughter described that she was in her mother's room one day when her mother was in bed, and had the call light on to go to the bathroom. When the aide came, the aide told CR2 that she can just go if she had a brief on. The aide further explained that she was busy, and she will be back. CR2's daughter was even more concerned about other aides shutting off the call light and sometimes don't come back. They would just say, I forgot.</p> <p>On 9/19/24 at 1:30 PM, the facility's Call Light Policy and Dignity and Respect Policy was reviewed.</p> <p>The Guidelines for Answering Call Lights specified:</p> <ul style="list-style-type: none"> . 5. Answer the resident's call light as quickly as possible. 6. Be courteous when answering the resident's call. 7. Ask permission to enter the room. 8. Call the resident by name: Mr. [NAME], how may I help you? 9. Provide privacy as needed by pulling the blinds, privacy curtains. <p>(continued on next page)</p>		

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