STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235729	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Veteran Homes at Grand Rapids	2950 Monroe NE Grand Rapids, MI 49505

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain complete and accurate medical records for 1 resident (Resident#25) of a total sample of 25, resulting in a potential for missed wound care and worsening of a wound going unrecognized. Findings include: Review of an admission Record revealed Resident #25 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: atherosclerosis (condition causing a narrowing of blood vessels due to the build up of plaque, pressure ulcer of the sacral region (lower back, base of spine, pelvic area), diabetes (condition resulting in elevated blood sugar levels), and chronic pain. Review of a Minimum Data Set (MDS) assessment for Resident #25 with a reference date of 2/25/25, revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #25 was moderately cognitively impaired. Review of a Care Plan for Resident # 25 with a reference date of 10/5/22, revealed a problem/goal/interventions of: (Resident #25) has .presence of actual pressure wounds .Goal: Intact skin will remain free of redness, blisters, or discoloration .Interventions .Notify the medical provider and wound nurse of any new skin issues, injuries or other skin related concerns . In an interview on 4/28/25 at 2:01pm, Resident #25 reported he had multiple wounds and that the staff changed the bandages once a week. In an interview on 4/29/25 at 12:54pm, Registered Nurse (RN) BB reported Resident #25 had multiple wounds, and the treatment was painful, so the resident only wanted it done once a week. In an interview on 4/30/25 at 9:35am, RN BB reported the Treatment Administration Record (TAR) for Resident #25 had no document of wound treatment being completed on 4/21/25 for Resident #25, which was the day the dressing change to his coccyx (base of the spinal column) was due. RN BB reported she would speak with the hospice nurse, who was responsible for completing wound care for Resident #25, and review documentation to determine if Resident #25 received wound care on 4/21/25. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/30/25 at 9:45am, Licensed Practical Nurse (LPN) ZZ reported Resident #25 did not refuse dressing changes to his wound on his coccyx. LPN ZZ reported if a treatment was not documented in the TAR, it would be documented in nursing progress notes. LPN ZZ also reported any refusals for dressing changes should be documented in nursing progress notes. Review of an email received from RN BB on 4/30/25 at 10:30am revealed I spoke with hospice and LPN ZZ. Hospice RN did not come in on 4/21 and they (hospice services) did not notify us until late in the day. LPN ZZ did the dressings (dressing changes for Resident #25) on 4/22. In an interview on 4/30/25 at 11:50am, RN BB reported documentation of weekly wound measurements, as well as evaluations of wounds was expected to be completed week. When further queried, RN BB reported the electronic medical record reflected the last measurements of Resident #25's wounds were dated 4/7/25. In an interview on 4/30/25 at 12:08pm, Wound Nurse/RN(WNRN) AA reported she tracked the completion of weekly wound evaluations and documentation of wound measurements at the facility. WNRN AA said the hospice RN was responsible for documenting the evaluation, treatments and condition of Resident #25's wounds. WNRN reported Resident #25 had recently received wound evaluations and wound care from hospice nurses that were filling in and not actually assigned to him. WNRN AA reported she had been gone for several days, and another nurse covered her responsibilities, but that nurse was still learning the role. WNRN AA reported she thought the lack of appropriate documentation regarding Resident #25's wound care and wound evaluations may have been overlooked and not corrected in her absence. WNRN AA confirmed Resident #25 had no documentation of wound measurements since 4/7/25 in his medical record. When further queried, WNRN AA reported it was important to have documentation of weekly wound care and wound measurements to determine if the wound was improving or worsening. Review of Principles for Nursing Documentation published by the American Nurses Association, 2010, revealed Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Review of a Pressure Injury Prevention and Management facility policy with a reference date of 4/11/25 revealed Policy: (Facility name omitted) is committed to .provide treatment and services to heal the pressure ulcer .5. Monitoring: The RN (Registered Nurse) .or designee, will review all relevant documentation regarding skin assessments .progression towards healing, compliance at least weekly .and document a summary of finding the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #100: Review of an admission Record revealed Resident #100 was a male with pertinent diagnoses which included cholecystectomy drain (thin tube inserted into the gallbladder to drain excess bile), pressure ulcer right heel, and deep tissue injury to left medial bunion near great toe. Review of Order dated 2/4/25, revealed, .Enhanced Barrier Precautions (EBP) related to: Chole drain - Ensure the precaution sign is posted and visible outside of member room (not on member door). - PPE supplies are available outside the room. - Touchless trash receptacle inside room near doorway for PPE disposal prior to exit . During an observation on 04/28/25 at 12:10 PM, Resident #100 was brought to his room to transfer him into bed. Certified Nursing Assistant (CNA) N was observed making Resident #100's bed. She grabbed the pillows off his bed and placed them in the chair. CNA N grabbed his personal blanket and quilt off the chair and placed them on his bed. There was no signage on the door to indicate he was on EBP. In an interview and observation on 04/28/25 at 12:13 PM, CNA N reported Resident #100 had a wound on his bottom. CNA N reported personal protective equipment (PPE) would be worn while bathing him and changing his brief as she was making his bed. During an observation on 04/28/25 at 12:15 PM, CNA N folded the blankets down and CNA M brought the hoyer in the room to transfer Resident #100 to his bed. CNA M reported Resident #100 had on the blue boots to protect his heels as he had a wound on his right heel. Both CNAs hooked the resident's sling up to the hoyer machine, rolled Resident #100 over to his bed, guiding him over the bed and stabilizing him while the hoyer was slowly lowered to the bed. CNA N had placed her hands on Resident 100's feet while he was slowly lowered to the bed. Both CNAs were on each side of him and removed the loops from the sling off the hoyer arm. CNA M removed the hoyer from under the bed and moved it out of the way. CNA M came back to Resident #100 had him roll towards her as she removed the sling and then had him roll to the other side to remove the sling from that side while she supported him and removed the sling from under Resident #100. CNA M then adjusted him in the bed so he was more centered and checked his brief to determine if he needed care. CNA N removed her gloves, cleaned the hoyer, performed hand hygiene and exited the room. Neither CNA wore a gown during cares. In an interview on 04/28/25 at 12:20 PM, CNA M reported the only time the staff would wear EBP PPE was when they were providing care to the resident when Resident #100's wounds were exposed. In an interview on 04/30/25 at 12:31 PM, Registered Nurse (RN) YY reported the staff would wear a gown and gloves while providing care to a resident who was under enhanced barrier precautions (EBP) as your clothes could spread whatever you had come into contact with to the resident you were providing care to. In an interview on 04/30/25 at 01:25 PM, Nursing Home Admininstrator (NHA) A reported when staff were providing hands on care to a resident under EBP, the staff were required to wear what the guidance was on the sign posted outside of the resident's door indicated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Enhanced Barrier Precautions policy last revised 4/1/24 revealed, POLICY It is the policy of MVH to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs) . 2. Initiation of Enhanced Barrier Precautions . b. An order for enhanced barrier precautions will be obtained for members with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy tubes) even if the member is not known to be infected or colonized with a MDRO .3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the member's room .4. High-contact member care activities include: a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy tubes. h. Wound care: any skin opening requiring a dressing . Based on observation, interview, and record review, the facility failed to implement and follow enhanced barrier precautions for 2 (Resident #419 and #100) of 25 sampled residents reviewed for infection prevention and control resulting in the potential for the development and transmission of communicable diseases and infections. Findings include: Resident #419 Review of an admission Record revealed Resident #419 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unstageable pressure ulcer of right heel. Review of Resident #419's Treatment Administration Orders (TAR) revealed, Order: Enhanced Barrier Precautions related to: unstageable ulcer to right heel/ dialysis access site. Ensure the precaution sign is posted and visible outside of member room (not on member door). PPE (personal protective equipment) supplies are available outside the room. Touchless trash receptacle inside room near doorway for PPE disposal prior to exit. every shift for transmission based precautions. Start date: 4/24/25. It was noted that nursing staff had documented this treatment order as completed each shift from 4/24/25 to 4/29/25. In an observation on 4/28/25 at 10:39 AM, Resident #419's room was noted to not have an Enhanced Barrier Precautions sign near the door or a cart with PPE for staff to wear for high contact care with Resident #419. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/29/25 at Licensed Practical Nurse (LPN) II and Certified Nursing Assistant (CNA) VV and CNA D entered Resident #419's room. LPN II administered oral medications to Resident #419 and then applied gloves and began to remove the dressing bandage on Resident #419's right foot. It was noted that LPN II was not wearing a gown. After LPN II completed Resident #419's medication administration, CNA VV and CNA D placed a hoyer sling (piece of equipment used with a hoyer lift to transfer patients with limited mobility) underneath Resident #419 and then attached the sling to the hoyer to transfer Resident #419 to his wheelchair. It was noted that CNA VV and CNA D did not wear gloves or gowns while assisting Resident #419. In an interview on 4/30/25 at 9:38 AM, Nursing Supervisor (NS) CC reported that Resident #419 had an order in place for Enhanced Barrier Precautions because of the open wound on his right foot. NS CC reported that Resident #419 should have had a sign near his door indicating that he was on Enhanced Barrier Precautions, and a cart outside of his room with PPE for staff to use. NS CC reported that she was unaware that Resident #419 did not have Enhanced Barrier Precautions in place. In an interview on 4/30/25 at 10:25 AM, CNA D confirmed that Resident #419 was not in Enhanced Barrier Precautions until the afternoon of 4/29/25. CNA D confirmed that staff had not been using PPE when providing care for Resident #419. In an interview on 4/30/25 at 12:28 PM, LPN II reported that she was unaware that Resident #419 was supposed to be on Enhanced Barrier Precautions. LPN II confirmed that the facility did not initiate Enhanced Barrier Precautions for Resident #419 until the afternoon of 4/29/25. In an interview on 4/30/25 at 1:57 PM, Infection Preventionist (IP) FF reported that Resident #419 was supposed to be on Enhanced Barrier Precautions because he had a wound. IP FF confirmed that the order for Enhanced Barrier Precautions was not placed until 4/24/25. IP FF confirmed that there was a breakdown in communication among the staff that placed the order and the staff that were supposed to follow the order and set Resident #419's room up for Enhanced Barrier Precautions, and that the facility missed this. IP FF confirmed that nursing staff were documenting that Resident #419's Enhanced Barrier Precautions orders were in place between 4/24/25 through 4/29/25, but that was inaccurate, as the facility had not placed Resident #419 into Enhanced Barrier Precautions until the afternoon of 4/29/25.