STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634550	A. BUILDING _____ B. WING _____	3/4/2025

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F0000 SS=	INITIAL COMMENTS Oakland Nursing Center was surveyed for an Abbreviated survey on 3/04/25. Intake: MI00150474. Census = 14.	F0000		
F0842 SS= D	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F0842	R 301 did not experience any adverse reaction to the alleged deficient practice. R301 discharged home with her daughters on 2/28/25 in stable condition. All residents have a potential to be affected by the alleged deficient practice. Policy and Procedure for the Documentation has been reviewed by the DON/LNHA and deemed appropriate. Physician staff Nursing team will be re-educated in regards to the Documentation Policy & Procedure with emphasis on: • Documenting time frame for consults. (Physician) • Documenting communication and education provided to resident/family. (Physician and Nursing) Administrator/DON or designee will conduct Physician and Nursing documentation audits to ensure compliance 3x/week for one month. Findings will be presented to QAPI Monthly x3 and PRN. Administrator/DON will be responsible for sustained compliance.	4/1/2025

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

Electronically Signed | 03/20/2025

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.

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	medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: This citation relates to Intake: MI00150474. Based on interview and record review, the facility failed to ensure accurate, complete, and timely documentation in the medical record for one Resident (R301) of two residents reviewed for documentation following a change in condition. Findings include: On 3/04/25 at 1:11 p.m., Family Member (FM) "C" reported R301 sustained a fragmented fracture of their right foot during their stay at the facility from rolling out of			

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	their bed on 2/17/25, and was never seen by podiatry services, despite a referral. FM "C" stated the facility treated R301's foot which had some edema with ice and elevation. FM "C" explained R301's foot remained swollen, however R301 had no pain or signs of infection in their right foot during their stay. FM "C" clarified R301 had no significant change in functional status, as they were mainly in bed prior to their fall due to some lethargy and weakness. FM "C" clarified they were told to make the podiatry appointment for R301 to be seen as an outpatient upon discharge from the facility, as they were not seen by podiatry services during their stay, which concerned them. Review of R301's census revealed they were admitted to the facility on 2/07/25 and discharged on 2/28/25. Review of R301's Care Plan, accessed 3/04/25, revealed R301 was non-ambulatory, could weight bear as tolerated on their legs, and required a Hoyer (full mechanical lift) for transfers due to lethargy, weakness, and fatigue. The Care Plan was not updated to reflect R301's non-weight bearing status after their fall on 2/17/25, per physician directive, and progression to slide board transfers upon discharge. Review of R301's Minimum Data Set (MDS) assessment, dated 2/13/25, revealed a score of 6/15 on the Brief Interview for Mental Status (BIMS) assessment, which showed severe cognitive impairment. Review of R301's Electronic Medical Record (EMR) revealed R301 was their own responsible party, and the facility was recommending their family pursue			

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	guardianship, due to R301's cognitive impairment, but this had not been completed during their shorter stay. Review of R301's EMR revealed a nursing assessment note, dated 2/17/25, which showed, " ...(R301) alert x 1 (to themselves), calm and cooperative. All meals and meds taken appropriately. (R301) found down on floor when doing morning walk through. Patient was assessed. Dr. (Physician "E") notified and (name of) Director of Nursing (DON). Writer observed what appears to be (an) injury to right ankle and x-ray order placed and completed. Waiting for results. Family notified. (R301) denies any pain and when touched or moved no s/s (signs or symptoms) of distress noted ..." It was noted edema was not marked on the assessment as present, and the box was left blank. Review of R301's fall investigation report related to the fall out of bed on 2/17/25, received from the DON, revealed R301 was found on their floor on the right side of their bed at approximately 7:25 a.m. R301 had not activated their call light. The report showed a head-to-toe assessment was completed, and showed their right foot was slightly swollen, and the physician was notified on 2/17/25 at approximately 7:30 a.m. The report revealed witness statements by the DON and fall interventions of a low bed and a fall mat added. Review of R301's X-ray report of their right ankle, dated 2/17/25, revealed small, displaced fracture fragments overlying the distal (lower) dorsal (posterior) margin of the talus and navicular bone (foot/ankle bones), likely reflecting a chip fracture (small chips of bone).			

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	Review of R301's physician notes by Physician "E", dated 2/17/25, revealed, "Late entry: 2/17/25 at 10:57 a.m., " ...Reason for visit: ...Fall ...Patient is seen and examined, discussed with staff, Vital signs, medications, available labs and chart reviewed. Review of system; (R301) poor historian ...Examination: ...1. Fall. X-ray obtained and showed R ankle chip fracture. Mild swelling. No distress. No pain. Instructed to ice and remain non-weight bearing. Consult with podiatry ...Plan was discussed with nursing and patient's daughter ..." It was noted no emergent transfer or orthopedic consult was recommended, and edema was present. Review of R301's physician provider notes, dated 2/27/25, 2/25/25, and 2/21/25, showed podiatry services was referred to evaluate due to right lower extremity fracture fragments, with no mention of any podiatry visit, follow-up, other referral, or treatment provided. Further review of R301's physician notes further revealed no mention or need for an acute emergent transfer, as pain was not charted, and only minimal edema. Review of R301's nursing progress notes revealed R301 was diagnosed with COVID (a highly transmissible viral infection) on 2/21/25 and was placed in isolation for the remainder of their stay. Family notification was documented on 2/21/25. Review of the EMR revealed no mention of why R301 was not seen by podiatry services during their stay, or any attempts to be seen by an in-house or outside podiatry provider. The EMR showed only a mention of podiatry services being referred in the physician notes.			

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	On 2/21/25 at 2:29 p.m., the Rehabilitation Director, Physical Therapist "D", was asked about R301's weight bearing status during their stay. PT "D" reported any patient with a new fracture should be non-weight bearing, until they were seen by a provider, which could have been either a podiatrist or orthopedic specialist. PT "D" stated R301 was non weight bearing in physical therapy. PT "D" reported they had not evaluated or treated R301 during their stay, and their treatment was completed by PT "F". Review of R301's progress notes during their stay with PT "D" revealed no documentation of a non-weight bearing status on their right or either leg in the PT notes. There was no mention of right foot pain, range of motion impairment, edema, or the right foot or ankle being addressed in PT assessments or treatment. Review of R301's physical therapy and occupational therapy notes after their fall on 2/17/25 confirmed no weight bearing had been attempted on their lower extremities, and R301 had completed slide board transfers only during treatment, with the standing goal discontinued by Physical Therapy after the 2/17/25 fall. On 3/04/25 at approximately 2:45 p.m., with PT "D" present, PT "F" was asked during a phone interview about R301's weight bearing status. PT "F" stated R301 was weight bearing as tolerated on their legs during their stay, however they had not done any weight bearing activities. PT "F" explained they had only worked with R301 on slide board transfers from bed to chair, bed mobility, trunk control, and sitting balance after their			

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	fall on 2/17/25. PT "F" reported R301 presented with mild edema in their right foot, which they termed lymphedema in both their feet from the first day of their stay, as fluid was collecting in their feet and legs from R301 being immobile. PT "F" reported they had been made aware of the chip fractures and were working on clarifying weight bearing with the DON, and R301 was treated as non-weight bearing in their legs in PT treatment after the 2/17/25 fall with chip fractures. PT "F" reported they recommended long term care and further therapy for R301 and the family chose to take R301 home. They clarified R301 was discharged prior to being seen by podiatry services, and they would have benefited from more therapy in-house. PT "D" confirmed R301 was not cut by insurance but rather R301's family requested discharge to continue therapy at home, before a podiatry visit could be arranged. Review of R301's EMR including physician orders revealed no documentation of R301 being non-weight bearing on their right lower extremity, other than the physician note on 2/17/25. Review of R301's EMR showed R301 was diagnosed with COVID on 2/21/25, was placed in isolation on 2/21/25 and remained on isolation until they were discharged on 2/28/25, which may have impeded their ability to go out for podiatry services. On 3/04/25 at 3:46 p.m., the DON was asked why R301 was not seen by a podiatrist during their stay, per Physician "E"'s referral on 2/17/25, and subsequent physician visits noting the referral, to address their acute right foot/ankle fracture and to clarify their			

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	weight bearing status. The DON reported they had attempted to have R301 seen by a podiatrist during their stay, and the designated podiatrist declined to contract with the facility in-house, as they had not had any recent referrals. The DON reported R301's family had declined to have them seen emergently at the time of the fracture, and during their stay, which they and Physician "E" had offered. The DON reported they had made some calls to outside podiatry providers and attempted to have R301 seen, however given their COVID status, the transfer was a concern and no providers wanted to see them outside the facility with COVID. This Surveyor clarified there was no documentation of these attempts and family declining an ER (emergency room) visit found in the EMR. The DON observed the same, and reported they should have documented this in the EMR and understood the concern. On 3/04/25 at 4:33 p.m., Physician "E" was asked during a phone interview, with the DON present, why R301 had not been seen by podiatry, and their weight bearing status was not further clarified during their stay. Physician "E" reported the chip fracture was very small and given R301's medical comorbidities and advanced age, it was not urgent for them to see a podiatrist, and R301 had no pain or tenderness in their right foot. Physician "E" indicated the podiatrist was the most appropriate referral. Physician "E" stated this was a minor fracture which would likely be expected to heal with conservative measures and clarified they had ordered ice and elevation (which was confirmed in physician orders and reportedly observed as provided by family). Physician "E" reported they had spoken to the family and offered			

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	emergency services, which the family declined. This Surveyor asked why this was not noted in the medical record. Physician "E" reported they had spoken to R301's family in person with the DON present on two occasions, and both times the family declined an emergent transfer, and wanted to take R301 home verses staying in long term care. The DON confirmed their responsibility for this not being documented in the EMR, as they were present on at least one occasion, and stated they understood the concern related to incomplete documentation. Review of the policy, "Documentation", dated 4/30/24, revealed, "Purpose: To provide guidelines for the healthcare provider regarding documentation in the patient's medical record ...Documentation is the process of preparing a complete record of the patient's care and is a vital tool for communication among healthcare team members ...7. If information listed on a form does not apply to your patient, write "N/A (not applicable)", rather than leaving the space blank. Documentation: 1. Assessment findings. 2. Care plan. 3. Adverse reactions, interventions, and patient's response to interventions. 4. Patient and family education ..."			