STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824519	A. BUILDING ______ B. WING ______	**12/21/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NSG & REHAB CANTON	**7025 LILLEY ROAD CANTON, MI 48187**

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F0000 SS=	INITIAL COMMENTS Promedica Skilled Nursing and Rehab Canton was surveyed for an abbreviated survey from 12/14/21-12/21/21. Intakes: MI00122442, MI00122713, MI00122872, MI00123119, MI00123183, MI00124480, MI00124707, MI00124961, MI00125128. Census: 90	F0000		
F0689 SS= J	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to intakes MI00125128 and MI00123183. This citation contains two Deficient Practice Statements. DPS#1 Based on observation, interview, and record review the facility failed to prevent 2nd degree burns from hot liquids in 1 of 13 residents (R13) reviewed for safety, resulting in an immediate jeopardy when on 12/5/21, R913 was given broth from the kitchen that was not cooled per facility policy before serving and R913 spilled broth onto chest resulting in 2nd degree burns (damage to	F0689	Element 1 DPS #1 Resident # 913 was identified and no longer resides in the facility. Resident #913 was sent to the hospital to receive treatment at the time of injury, returned, and later successfully discharge from the center on 12/24/21. No specific corrective action could be taken for this resident at the time of the survey however the medical record has been reviewed for additional educational and quality improvement opportunities. DPS # 2 Resident # 905 was identified and no longer resides in the facility. Resident # 905's was picked up from his appointment by family and admitted to an area Assisted Living Facility. No specific corrective action could be taken for this resident at the time of the survey however the medical record has been reviewed for educational and quality improvement opportunities Element 2 DPS #1 Like residents who have the potential to be affected are those who consume hot beverages from the facility kitchen. The facility kitchen equipment contractor lowered the temperature of the water heating induction system to approx. 160 degrees to ensure hot	1/26/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/24/2022

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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the skin includes the outer layer and penetrates the middle layer of tissue) to left chest and flank area. This deficient practice has the likelihood for all residents who eat foods from the kitchen to sustain burns at the facility causing serious injury and harm.

Findings include:

In an observation on 12/21/21, the kitchen hot water pot where R913's broth was made from was temped and the water was 190 degrees.

During interview on 12/21/21 at 11:38 AM with Certified Dietary Manager (CDM) "F", she was asked about the incident with resident R913 and said, "We have a heating induction system- where coffee is brewed. We call it "Bunn water". That water comes out at least 180 degrees if not hotter. When we make these broths, the dietary staff will put water in container and let it cool down before putting lid on it. It will then allow the broth to cool down before giving it to the patient. I spoke with Dietary Aide "G", and I was told they came down for a tray and she was in the middle of other things, and she didn't let it cool down before sending off tray to resident." CDM "F" confirmed that the staff did not follow proper procedures.

During observation on 12/21/21 at 11:58 AM in the kitchen area, CDM "F" used an electronic thermometer to measure water out of heating induction unit (coffee and water maker) it was observed to be at 190 degrees Fahrenheit.

During interview on 12/21/22 at 1:10 PM with Administrator "A" it was confirmed that the kitchen should follow all policies when dispensing food to residents

Review of "Hot Beverage Safety" policy dated November 2019 documented the following: " ...

beverages and broths are served between 150-155 degrees as recommended in the facility Hot Beverage Safety Policy. A baseline audit of hot liquids/soups at point of service was conducted and found none to be out of range.
DPS #2 Like residents who have the potential to be affected are those residents who have and attend scheduled appointments with cognitive impairment needing supervision as evident by a BIMS score <13. The facility reviewed scheduled appointments from 12/21/21, to validate supervision was provided to residents as indicated.

Element 3
DPS #1 The department heads educated staff on the Hot Beverage Safety Policy. CDM educated kitchen staff regarding hot liquid temperature logs.
DPS #2 The Medical Records Director educated the Unit Secretary (E) on the procedure for scheduling and validating resident external appointments that require supervision. The Administrator educated the IDT on the procedure to review the resident appointment schedule validation process.

Element 4
DPS #1 CDM(F)/designee will complete Point of Service Temperature audits of hot beverage/broth temperatures, 5 times weekly for 4 weeks to verify temperatures are compliant per Hot Beverage Safety Policy. Findings will be reviewed by the Administrator, who will submit to QAPI committee for further review and recommendations.
DPS #2 Medical Records Director/designee will complete random resident audits of Scheduled Resident External Appointments 3 times weekly, times 4 weeks to validate scheduled appointments for residents

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consider the temperature range of 150-155 F as an approximate guide for hot beverages leaving the kitchen; record the temperature taken on the Food Temperature Log

Review of 913's face sheet revealed admission into the facility on 12/5/21 with diagnoses that included syncope (fainting), collapse, and heart failure.

According to the Minimum Data Set (MDS) dated 12/8/21, R913 had intact cognition.

During interview on 12/21/21 at 9:10 AM with R913, it was confirmed she sustained a 2nd degree burn after spilling hot broth on her chest. When asked about incident R913 stated," I asked to be given chicken broth, jello, and hot tea for dinner. When I went to pull the bowl toward me to drink it with a straw it caught on the side of the tray and spilled out. They never told me how hot it was before they gave it to me. I had to go to the burn center to get treatment."

On 12/21/21 at 1:34 PM, Administrator "A" was notified of the Immediate Jeopardy (IJ) that began on 12/5/21 due to the facilities failure to follow facility policy on cooling hot liquid prior to serving to prevent a 2nd degree burn on R913's chest and flank.

A written plan of removal for the immediate jeopardy was received and verified on 12/21/21.

Actions:

1. Resident R913 identified

2. Patient assessed for injuries with the following findings: redness across chest, abdomen, and left side

requiring supervision are identified as indicated. Findings will be reviewed by the Administrator who will submit to the QAPI committee for further review and recommendations.

Element 5
The Administrator will be responsible for achieving and sustained compliance. The compliance date is 1/26/22.

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	3. Patient treated with cold compress to cool/soothe injury site photo taken for record 4. Per MD order patient sent to hospital 5. Family notified on 12/5/2021 6. Incident report created 12/5/2021 7. Investigation initiated on 12/5/2021 8. Care Plan reviewed and updated on 12/6/2021 9. QAPI Committee meeting held on 12/6/2021 @ 9am to review investigation process and to develop additional recommendations 10. Dietary staff education initiated on 12/6/2021 Abatement 12/21/21: 1. Patient R913 identified 2. QAPI Committee Ad-HOC Mtg. 1:45pm 3. Like Patients identified as all patients who consume food and beverage from the facility kitchen (84) 4. Reduced temperature of in-house coffee urn to 160 degrees @ 2:35PM 5. Policy Review: hot beverages should leave the kitchen between 150-155 degrees 6. Kitchen staff re-education: Hot Beverage Safety. All staff will be educated prior to beginning of next shift. All five staff currently in-house completed. 7. Education provided to 100% of staff currently			

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in-house, on the importance of hot beverage safety. All off-duty staff will be educated prior to returning to work.

Monitoring:

1. Random interviews of dietary staff in process pertaining to "hot beverage safety".

2. Daily audits by Dietary Manager/Designee, for five weeks of hot-liquid.

3. Temperatures leaving the kitchen to ensure temperatures are within 150-155.

4. Results of audits submitted to the QAPI Committee for review and recommendation.

Compliance:

1. The administrator is responsible for achieving and maintaining compliance.

Although the immediate jeopardy was removed on 12/21/21 the facility remained out of compliance at a scope of isolated and severity of actual harm due to facility education had not yet been completed and sustained compliance had not yet been verified by the State Agency.

DPS#2

Based on interview and record review the facility failed to provide adequate supervision for a confused resident, affecting one resident (R905) out of three residents reviewed for supervision, resulting in the resident being left at an appointment with no direct supervision against the families wishes.

Findings include:

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During telephone interview on 12/15/21 at 10:23 AM with R905's family member, it was confirmed that the facility was made aware that R905 was only to go to appointments with family. It was confirmed that resident needed supervision because he was confused. It was confirmed that facility transported the resident to the wrong location and R905 was left there in a wheelchair.

Review of R905's face sheet revealed admission into facility on 9/22/21 with a pertinent diagnosis of malignant neoplasm of brain (cancer).

Review of "General Progress Notes" revealed the following:

9/23/21 at 16:25, Social Service Note: "BIMS (brief interview for mental status) assessment completed with a score of 12 indicating moderate cognitive impairment."

9/25/21 at 4:24: Note Text- "Pt. (patient) is alert and oriented x 2 with confusion and forgetfulness."

9/25/21 at 15:16- Note: "Patient is alert and oriented with slight confusion."

9/25/21 at 21:55- Note text: "Patient is alert and oriented with forgetfulness."

9/26/21 at 20:21: General Progress: "Patient is A&O x3 (alert and oriented to person, place and time) with confusion. He requires cuing when taking his meds and doing any tasks.

During interview on 12/20/21 at 10:38 AM with Unit Secretary (US)" E" it was confirmed that the son of R905 had informed her that resident was not to go anywhere without family. It was confirmed that she cancelled the appointment that was made for the resident to go to appointment.

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	US "E" verbalized that another appointment was set up by previous unit secretary and she was not aware. The resident was sent to the appointment without any supervision. It was confirmed when residents are confused and family are not available, staff would be sent for supervision. During interview on 12/20/21 at 11:19AM with Director of Nursing (DON) "B", it was confirmed that she was not aware of situation until the time it transpired. When asked if residents that are confused should have supervision at appointments, DON "B" verbalized "Yes, but the resident with scores that high doesn't need it. I would have not sent staff with him." After request no policy was provided for transportation of confused residents was provided.			
F0697 SS= D	Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00122442. Based on interview and record review the facility failed to ensure timely pain control, in 1 of 3 residents (R901) reviewed for pain management, resulting in the potential of unmet pain control. Findings include: Review of R901's face sheet revealed admission into facility on 7/8/21 with a pertinent diagnosis of right sided femur fracture (broken thigh bone).	F0697	Element 1 Resident #901 was identified and no longer resides at the facility. Resident #901 insisted on returning to the hospital for additional pain remedies and did not return to the facility. No specific corrective action could be taken for this resident at the time of the survey however the medical record has been reviewed for educational and quality improvement opportunities. Element 2 Like residents were identified as those patients newly admitted to the facility, or with a pain medication order change, or those with a pain score between 8-10. Those residents with a pain score of 8-10, had their pain regiments/care plans were reviewed and updated as necessary to validate pain medication was provided. Element 3 The DON/Designee educated the nurses on	1/26/2022

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	Review of "Admission/Readmission Evaluation" dated 7/8/21 (no time) documented the resident was alert and oriented to person, time, and place. It was documented that R901 on admission reported 9 on a pain scale of 1-10 (10 worst pain). During interview on 12/16/21 at 10:58 AM with Registered Nurse "C", it was confirmed that resident was missing two prescriptions upon arrival from hospital to control pain and Physician "B" was made aware on 7/8/20 at 7:00PM. It was confirmed that an order was received from Physician "B" for Tylenol 650mg (milligrams) to be given every six hours for pain and was not entered into 901's medical chart. Review of "Medication Administration Record (MAR)" dated for the month of July 2021 revealed no orders for Tylenol 650mg every 6 hours for pain as needed. Further review of MAR revealed that R901 received first dose of Norco (Narcotic analgesic)10/325mg every 4 hours as needed for pain on 7/9/21 at 3:56 PM. Record review of "Pain Level Summary" documented the following: 7/9/21 at 10:14 - pain level 6 7/9/21 at 15:56 - pain level 6 7/10/21 at 08:30 - pain level10 7/10/21 at 11:54 - pain level 8 During interview on 12/16/21 at 11:35 AM with Director of Nursing (DON) "B", It was confirmed that resident was in facility more than 20 hours before she was given a narcotic analgesic for pain. It was confirmed by DON "B" that would be a long time to wait for sufficient pain control after		pain management practices and medication order reconciliation. Element 4 The UM/Designee will conduct random resident audits on pain management 3 times weekly, times four weeks. The UM/Designee will conduct newly admitted patient/new pain medication order/pain score 8-10 audits 3 times weekly, times four weeks to validate accurate reconciliation of medication orders. The results will be reviewed by the administrator, who will submit to the QAPI committee for further review and recommendation., times four weeks. Element 5 The Administrator will be responsible for achieving and sustained compliance. The compliance date is 1/26/22.	

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	having a surgery for a broken femur. It was confirmed that R901's pain was not managed in a timely manner and that no other interventions were documented to relieve residents' pain. It was confirmed that all physician orders should be entered into the resident's medical chart when given by physicians. During interview on 12/20/21 at 2:01 PM with Physician "D" it was confirmed that an order for Tylenol 650 mg to be given every six hours for pain was ordered and given to Registered Nurse "C" via phone. It was confirmed that resident's pain should have been addressed in a timely manner. Physician "D" confirmed Nurse should have made him aware that resident declined Tylenol order so that other decisions related to pain control could have been implemented. Record review of "Pain Management Guideline" original date 11/2021. The following information was documented: "Purpose: To describe the process steps required for interventions to prevent and or manage both acute and chronic pain ". ...Pain scores of 4-7 twice in a seven-day period or those who have a single score of 8, 9 or 10 are: Reported to the medical practitioner for consideration of treatment adjustments."			