STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	1/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHABILITATION CENTER	19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076

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F0000 SS=	INITIAL COMMENTS Evergreen Health and Rehabilitation Center was surveyed for an Abbreviated survey on 1/30/24. Intakes: MI00142295, MI00142293, MI00142273, MI00141529. Census = 84	F0000		
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00141529. Based on interview and record review, the facility failed to assess and treat a resident who expressed pain for one (R804) of two residents reviewed for changes in condition, resulting in unrelieved pain. Findings include: Review of a complaint submitted to the State Agency revealed the following allegations: "...(R804) discharged from the hospital and was transferred to (facility) around 1:30 PM on 12/7(2023). After being transported to her room, (R804) did not see another staff member until about 9:30 PM, and only after family intervened. (R804) la <sic> in her bed	F0684		

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

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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	bleeding and in pain. She tried many times to use her call light, however, no staff came to assist her. She eventually called her daughter by phone, who then called the facility directly and also 911 to have (R804) transported back to the hospital..." Review of R804's clinical record revealed R804 was admitted into the facility on 12/7/23 and was discharged to the hospital on the same day with diagnoses that included: malignant neoplasm of endometrium (uterine cancer). The clinical record indicated R804 was alert and oriented to person, place, time, and situation. Review of R804's hospital records revealed R804 arrived at the hospital on 12/7/23 at 10:37 PM. Review of the "ED (Emergency Department) Provider Notes" dated 12/7/23 revealed R804 presented to the ED with "vaginal bleeding". The following was documented, "...stage III uterine carcinosarcoma and PE (pulmonary embolism) on (blood thinner) who presents with vaginal bleeding. She was discharged earlier today to SAR (subacute rehab) from (hospital)...She states the SAR was 'terrible' and that 'no one checked on me'. She reports vaginal bleeding that began today. She is unsure of the amount, but said 'it was a lot'. She has lower abdominal pain that is rated a 10/10 in severity. Patient also reports fatigue, bilateral LE (lower extremity) edema, and nausea...Physical Exam...in acute distress...generalized abdominal tenderness..." Review of a "H&P (history and physical)" completed in the hospital revealed, "...Patient states that she had sudden onset severe			

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	vaginal bleeding...Patient called her daughter because she had been asking for help from nursing staff and had not received care of evaluation of her bleeding throughout her duration in the facility. The daughter called 911 to bring the patient from there nursing facility to the emergency department for evaluation...She also has 10/10 lower abdominal pain which is chronic for her..." Further review of R804's nursing facility clinical record revealed the following: Review of a "Pain Assessment" dated 12/7/23 at 3:13 PM, R804 experienced mild pain. Review of Physician's Orders revealed an order to assess the resident for pain every shift. R804 had the following orders for pain medications: Hydrocodone-Acetaminophen 5-325 milligrams (MG) every six hours as needed Oxycodone HCl 5 MG one tablet every four hours as needed Oxycodone HCl 5 MG two tablets every four hours as needed Review of R804's progress notes revealed the following notes: On 12/7/23 at 4:28 PM, Licensed Practical Nurse (LPN) 'F' documented, "...Denies pain or discomfort...NP (Nurse Practitioner) called and made aware of resident and meds (medications). States well <sic> be in to writer scripts (prescriptions)..."			

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	On 12/7/23 at 11:15 PM, Registered Nurse (RN) 'E' documented, "Writer received report from admitting nurse at approx (approximately) (4:15 PM). Writer did rounds on patient, asked about any pain or discomfort, resident denied any pain or discomfort...Writer notified by nursing staff approx 8:30 PM that resident was having discomfort and pain. Writer checked MAR (Medication Administration Record) for PRN (as needed) medications. NP called and requested scripts for PRN medications. Pharmacy contacted and authorization to pull (narcotic) faxed at 9:30 PM (one hour after RN 'E' was notified that R804 had "discomfort and pain"). Writer made attempt with second nurse to retrieve PRN (Oxycodone) from Pyxis (medication back up supply), medication not available. Pharmacy contacted once more about auth (authorization) to pull and was told medication would be available within 10 minutes. Medication not available at that time again. Writer called to unit regarding patient having large amount of bleeding coming from perineal area (patch of skin between the vagina and anus). NP notified at (9:45 PM) and ordered to send patient out to hospital...911 called at (10:00 PM)...patient left building...at approx 10:15 PM...left in stable condition no signs of distress observed...HR (heart rate) 125 (beats per minute)..." On 1/30/24 at 3:17 PM, an interview was conducted with RN 'E' via the telephone. When queried about what was done when R804 expressed pain on 12/7/23, RN 'E' reported the Certified Nursing Assistant (CNA) informed her that R804 was in pain. RN 'E' explained they looked in the medical record, saw there were orders for pain			

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	medications, but there were no scripts. RN 'E' reported she then called the provider to get a script and then followed up with the pharmacy to get authorization to pull from the back up supply. RN 'E' reported when they went to pull the medication from the back up supply "it wasn't available". RN 'E' explained the authorization was not available so they called the pharmacy again and they explained the authorization would be available in about ten minutes. RN 'E' waited and the authorization still did not come through so they went back to the unit and that was when they were notified that R804 was bleeding. When queried about where R804's pain was located, what the level of pain was, and if R804 had bleeding at the time the pain was expressed, RN 'E' explained they did not go into R804's room and did not assess R804 after the CNA had notified them of the pain and "just went right to call the NP and try to get the medication". When queried about whether the provider was contacted when there was a delay in getting authorization for the prescribed pain medication, RN 'E' reported they did not contact the provider for potential alternative pain treatment. RN 'E' reported she would have done that, but R804 ended up going to the hospital. On 1/30/24 at 2:37 PM, an interview was conducted with the Director of Nursing (DON). When queried about the facility's protocols to ensure residents' pain was managed and what to do if prescribed pain medication was not available, the DON reported if a script did not come over from the hospital for a new admission, the provider was contacted for a script. If the medication was needed before the medication was available, the pharmacy was			

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	contacted for authorization to pull from the back up supply. The DON further explained that if there was a delay in obtaining pain medication for a resident, the provider should be notified to see if an alternative form of pain relief could be administered. When queried about what the nurse should do if they are notified that a resident was experiencing pain, the DON reported the nurse should determine where the pain is located and what the level of pain is. When queried about whether R804 should have been assessed by the nurse after she expressed pain, the DON reported the resident should have been assessed and reported the nurse was trying to "do the right thing" and get the medications. The DON reported R804's family member called up to the facility and was "angry and upset" and spoke with a supervisor who then went to R804's room and discovered she had vaginal bleeding. When queried about why the daughter called up to the facility, the DON reported she claimed R804 had pressed her call light and nobody answered it, but the DON reported the CNA said that was not true. Review of a facility policy titled, "Pain Management Program", dated 3/1/2010, revealed, in part, the following: "...The assessment will describe and characterize the pain, including location, cause of pain...type of pain, chronic vs. acute, and intensity level. A scale of 0-10 will be used..."			
F0689 SS= D	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	F0689		

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	receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00142295 and MI00142293. Based on observation, interview, and record review, the facility failed to ensure safe positioning in a wheelchair with access to a call light for one (R801) of two residents reviewed for falls, resulting in a fall from the wheelchair and sustaining a bump to the head. Findings include: Review of a complaint submitted to the State Agency revealed the following allegations: "...facility staff put the resident in her wheelchair with a pillow on the seat and it was slippery...staff didn't lock the wheelchair and they didn't put the residents call light within reach before leaving the room...the resident used her cellphone to call her daughter and tell her she was falling out of her wheelchair and needed help...staff didn't get to the residents room until after she fell out her wheelchair and onto the floor...the resident hit her head and right shoulder and...blacked out...resident does have a knot on her head where it hit the floor..." On 1/29/24 at 3:05 PM, R801 was observed lying on her side in bed. Bed was not in the lowest position and the call light was observed on the recliner chair which was not within reach of the resident. R801's door was closed. On 1/30/24 at approximately 11:00 AM, R801 was observed lying on her right side in bed,			

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	spitting up into a plastic bin. When queried about any falls, R801 reported she fell from her wheelchair a little over a week ago. R801 explained the nurse aide assisted her into the chair and did not lock the brakes. R801 reported after being up in the chair for about a half hour, she got tired and wanted to get back into the bed, but could not reach the call light. R801 reported she felt like she was slipping down in the wheelchair and called her daughter to contact the facility so that someone could come help since she could not use the call light. R801 reported she waited about 20 minutes and nobody came. At that time, R801 explained it felt like the wheelchair was moving backwards and she was slipping down. R801 reported she slid out of the wheelchair and hit her head on a "scale" that was nearby. Review of R801's clinical record revealed R801 was admitted into the facility on 1/18/24 with diagnoses that included: abscess of liver, sepsis, and obstruction of the bile duct. Review of a progress note written on 1/18/24, on the day of R801's admission, revealed R801 was alert and oriented to person, place, time, and situation. Review of a progress note written by Licensed Practical Nurse (LPN) ' on 1/20/24 at 11:48 AM, revealed, "Writer walked into resident's room, resident observed on the floor in front of her wheelchair. When asked what happened? Resident stated, 'I slide from my wheelchair to the floor and hit my head, I couldn't reach the call light because it was on the floor.' Daughter was on the phone trying to talk to her mother when I walked in...Resident reported pain on her right			

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	head..." On 1/30/24 at 1:50 PM, an interview was conducted with LPN 'B' via the telephone. When queried about R801's fall on 1/20/24, LPN 'B' reported she was charting at the nurses' station and R801's daughter called and asked to check on R801. When LPN 'B' arrived to R801's room, R801 was on the floor in front of the wheelchair. LPN 'B' asked R801 what happened and R801 reported she wanted to go back to bed and slid from the chair to the floor. When LPN 'B' asked R801 why she did not use the call light, R801 explained she could not reach it. LPN 'B' reported R801 was sent to the hospital because she said she hit her head. LPN 'B' reported it was discovered the nurse aide placed pillows in the wheelchair and they should not have been placed there. On 1/30/24 at 1:58 PM, an interview was conducted with Certified Nursing Assistant (CNA) 'C'. When queried about R801's fall on 1/20/24, CNA 'C' reported when she assisted R801 into her wheelchair, R801 asked her to put pillows under her bottom and behind her back for support. CNA 'C' reported she placed the pillows per the resident's request and left the room. CNA 'C' reported the nurse notified her that R801 had fallen. CNA 'C' could not remember if the call light was placed in reach of R801. On 1/30/24 at 2:27 PM, an interview was conducted with the Director of Nursing (DON). When queried about R801's fall on 1/20/24, the DON reported it was discovered the CNA placed a pillow in the wheelchair and there should be no pillow except the gel cushion made for the wheelchair. The DON reported R801 slid from the wheelchair			

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	because of the pillow. According to the DON, R801's family member called the nurse's station because R801's call light was not in reach. Review of R801's care plans revealed a care plan that read, "Resident is at risk for falls...able to use call light to seek staff assistance..."			