STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	614010	A. BUILDING _____ B. WING _____	**4/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE NURSING CENTER	**2053 S SHERIDAN DRIVE MUSKEGON, MI 49442**

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F0000 SS=	INITIAL COMMENTS Christian Care Nursing Center was surveyed for a re-visit survey on 4/16/2024. Census=47	F0000		
F0684 SS= G	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: Based on interview and record review, the facility failed to ensure admission orders were thoroughly reviewed and transcribed accurately, and pertinent physical assessment findings recognized and promptly addressed for 1 resident (Resident #49) out of 3 closed records reviewed, resulting in two hospitalizations due to missed orders and failure to address a change in condition in a timely manner. Findings: Resident #49 (R49) Review of an "Admission Record" reflected R49 admitted to the facility on 3/21/2024 with diagnoses that included sepsis, localized edema, atrial fibrillation, sick sinus syndrome, atrial flutter, pulmonary hypertension, high blood pressure, acute embolism and thrombosis of unspecified deep veins of lower extremity, muscle weakness and bladder neck obstruction.	F0684	F684 1. Resident #49 no longer resides in the facility. The facility thoroughly reviewed this incident, including with facility medical director during QAPI on 5/20/2024. The root cause of this incident is the facility did not obtain a weekly weight per orders to identify an acute change in CHF conditions. 2. All current residents have the potential to be affected by this deficient practice. Current residents' records were reviewed to assess any recent change in condition and ensure interventions were appropriate and timely, this will occur daily in A.M clinical meeting going forward. Newly admitted resident's admission orders are being checked by a second nurse to confirm accuracy as of 5/14/2024. 3. Policy on Identifying and Responding to acute changes in condition was reviewed and deemed appropriate. Education provided to licensed nurses on appropriate procedures for identifying change of condition and reviewing/confirming admission orders by 5/14/2024. 4. The QAPI committee has directed the DON/designee to perform random weekly audits on 20% of all residents to ensure any change of condition is identified and treated timely, and newly admitted resident's orders are accurate. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow up and review.	3/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/18/2024

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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	Review of a hospital "After Visit Summary" dated 3/21/2024 (the day R49 admitted to the facility) reflected "Instructions: Patient (R49) has been having labile INR (international normalization ratio, a measure of how long it takes for blood to clot) measurements. He typically takes warfarin (a blood thinning medication) 5 mg (milligrams)daily but suspect he will need lower dosing for now. His INR was 2.8 on 3/19 and warfarin 2.5 mg was given which raised his INR to 3.5 on 3/20. No dose was given on 3/20 and his INR was 3.2 today on discharge. He will need daily INR monitoring until he reaches a more steady state." (Normal range for PT is 11-35 seconds. INR of 0.8 to 1.1) Review of a hospital "Encounter Summary" dated 3/21/2024, scanned into the facility Electronic Medical Record (EMR) on 4/7/2024 reflected a "Discharge Summary" which included "Continue daily weights and strict I & O (intake and output), Continue PO (oral) Lasix (a diuretic) 20 mg daily. Review of the facility "History and Physical" (H & P) report dated 3/27/2024 written by Medical Director (MD) "N" reflected R49 had a "Past Medical History" of congestive heart failure (CHF), warfarin induced coagulopathy, history of recurrent DVT (deep vein thrombosis) and bladder outlet obstruction status post Foley catheter. The H & P also noted R49 had "labile INRs". "Review of Systems" reflects R49 felt his weight has been stable, MD "N" noted "lower extremity edema". "Physical Exam" findings indicate "Lungs are clear to auscultation ... He (R49) had trace to +1 pretibial edema, but he also had edema extending up to his posterior thighs bilaterally." The "Assessment and Plan" reflects,."Recommend routine follow-up with cardiology. He has significant lower extremity edema. Recommend increasing his furosemide (Lasix, a diuretic) from 20 mg a day to			

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	furosemide 40 mg a day. Recommend rechecking a basic metabolic profile in approximately 10 days. Continue Coumadin (warfarin) 5 mg at bedtime. Recommend weekly protimes (PT) and as needed. INR checked on 3/25/2024 was 2.81 ...". Review of the March 2024 "Medication Administration Record" (MAR) and "Treatment Administration Record" (TAR) did NOT reflect R49 was being weighed as ordered in the discharge summary. Weekly protimes were ordered as per MD "N" recommendation despite hospital discharge instructions directing daily PT/INR monitoring. Review of a "Dietary Note" dated 3/28/2024 reflected "Continue to monitor weight", however, no frequency for weight monitoring was indicated. Review of a "Health Status" note dated 3/30/2024 reflected, " ...Resident wanted his oxygen level checked. Lungs sounds are clear but dim bilaterally, O2 (oxygen) is 93% on RA (room air). Resident stated he just likes to have it checked because he feels short of breath once in a while but not right now. Reassured resident we are happy to do that and his O2 level is good. Will inform oncoming nurse and continue to evaluate." Review of a "Health Status" note dated 3/31/2024 reflected, " ...Resident noted with edema to bilateral hands and legs, resident states this is an ongoing issue, does receive routine Lasix." The note references edema in R49's hands, which is a progression from the physical exam noted by MD "N" on 3/27/2024. Review of a "Health Status" note dated 4/1/2024 reflected the weekly scheduled PT/INR lab had			

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	not been drawn. The nurse notified the provider who ordered the lab to be drawn the following lab day which was scheduled for three days later. No adjustments were made to R49's dose of blood thinning medication. Review of an "IDT Note" (Interdisciplinary Team) dated 4/2/2024 reflected R49 was at the facility for IV (intravenous) antibiotics, physical and occupational therapy. The note indicated "His (R49's) biggest barrier is endurance and SOB (shortness of breath). Resident does have pulmonary hypertension diagnosis. Alternative options are being considered at this time. Will follow up in next week's Medicare meeting." The note did not specify any "alternative options". Review of a "Health Status" note dated 4/2/2024 reflected, " ...(R49's) Transfers are stand pivot with x2 EA (extensive assist). He needs EA assist (sic) with both upper and lower body dressing as he is very deconditioned, and caution needed with the PICC (peripherally inserted central catheter) line. He is not able to ambulate at this time and can barely stand long enough for staff to complete hygiene post toileting ...". Review of a "Health Status" note dated 4/3/2024 at 11:51 a.m. reflects, "(R49) is swollen around his groin area and his hands, C/O (complains of) SOB, went and asked MD "N" to look at him." Review of R49s "Weight Summary" accessed from the EMR reflected on 3/21/2024 R49 weighed 167.0 pounds. On 4/3/2024 at 1:59 p.m. R49 weighed 191.4 pounds, a 24.4-pound gain in 13 days. Review of a "Health Status" note dated 4/3/2024 at 4:38 p.m. reflected, "Resident was seen by provider today r/t (related to) fluid retention. Labs and medications reviewed. Catheter placement			

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	adjusted is patent and draining. Provider gave new orders with verbal instruction if resident declines or does not seem to be improving to call provider or on-call and send resident to hospital ...". Weekly weights were ordered at this time, as well as increased dose of diuretic (Lasix) medication." (The diuretic was increased to twice daily). Review of a "Health Status" note dated 4/3/2024 at 9:05 p.m. reflected R49 continued to have edema to hands and groin and was started on 1 liter of supplemental oxygen via nasal canula (NC) for a pulse oximetry reading of 88%. The note indicated R49 had 200 milliliters of urine output. Review of a "Health Status" note dated 4/4/2024 at 1:14 p.m. reflected, "Bladder scan completed a pt (patient, R49) had such low urinary output on MN (midnight) shift. 20 cc (cubic centimeters) found to be in bladder mid am (morning) ...Pt did ask to have O2 on ...O2 @ 2L (liter) per NC applied. He does have firm edema up to mid torso." The note does NOT indicate the physician was notified of the increased need for supplemental oxygen or progressive edema. Review of a "Health Status" note dated 4/4/2024 at 6:41 p.m. reflects, "Resident sent to (Hospital) ER (emergency room) per doctor's order for critical labs. PT 82.3 INR 8.53. All appropriate parties notified." Review of a "Health Status" note dated 4/5/2024 at 4:17 a.m. reflected R49 returned from the ER at 2:15 a.m. after getting a dose of Vitamin K (to help clot blood) and IV lasix. Review of a "Health Status" note dated 4/5/2024 reflected, "Resident seen by PCP (primary care provider) for acute visit on 4/4/2024.			

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	Review of a "Health Status" note dated 4/7/2024 at 11:20 a.m. reflected, "This pt admitted on 3-21 with a wt. (weight) of 167. He was on Lasix 20 mg daily, on 3/29 his Lasix increased to 40 mg daily. On 4/3 his wt. was 191.4 and his Lasix was increased to 40 mg BID (twice a day). Today his wt. is 193.6 His lungs are fairly CTA (clear to auscultation), but quite diminished. He states he is more tired than he has been in a long time. He has firm edema up to the nipple line. I placed a call to the on-call Dr. (name of provider) who instructed me to send him to the hospital to be admitted for diuresis. He is now on 2L O2 per NC. This is new over the past couple days." Review of the "Weight Summary" reflected R49 weighed 193.6 pounds on 4/7/2024 at 7:55 a.m., indicating he had gained an additional 2 pounds since his weight on 4/3/2024, for a total weight gain of 26.6 pounds in 17 days at the facility. During an interview on 4/16/2024 at 1:53 p.m., Assistant Director of Nursing (ADON) "A" was asked about R49 course of stay at the facility. ADON "A" said that she was not involved in completing admissions at the facility, Registered Nurse (RN) "B" was. ADON "A" reviewed the concerns identified in the clinical record and said it was concerning that weights had not been monitored for R49 and no physician notification had been done despite documented changes in R49's condition (SOB/use of supplemental O2/increased edema/low urine output). During an interview on 4/16/2024 at 2:00 p.m., the Director of Nursing (DON) was asked if she had reviewed R49's clinical record due to his unplanned hospitalizations. The DON said she had not reviewed the clinical records. ADON "B" explained the concerns that had been identified due to the surveyor review. The DON said that it would be a good idea to review the clinical record			

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	of residents who discharge to the hospital to evaluate for areas of improvement and to prevent hospitalizations in the future. During an interview on 4/17/2024 at 8:13 a.m., Registered Nurse (RN) "B" reported she completes most of the admissions at the facility. RN "B" said that the facility gets a packet of information from the hospital, and she makes sure that the packet matches what is in the chart via (name of hospital EMR) which the facility has direct access to. According to RN "B", she did not see the order for daily PT/INR laboratory draws. RN "B" said she did not see that hospital providers recommended daily weights or strict input and output monitoring. During an interview on 4/17/2024 at 9:08 a.m., MD "N" said that upon admission, R49's heart failure was not a top priority, and he did not see an order for daily weights or strict I & O and did not order weight monitoring. MD "N" said that monitoring strict I & O is just "not done" in Long Term Care because of the inaccuracy and resident access to fluids. According to MD "N", he did not note the hospital discharge instruction to monitor PT/INR daily for R49. MD "N" said he was very concerned about R49's PT/ INR and was very worried about the missed lab draw for PT/INR on 4/1/2024. MD "N" reported he has not been happy with the current laboratory provider and had spoken to the facility about getting a contract with another lab even before the missed PT/INR lab for R49. MD "N" said that R49 was a very sick person, and his fluid retention/edema was compounded by other diagnoses which was why the resident was still in the hospital as of the date of the interview on 4/17/2024. Review of a hospital "History and Physical" dated 4/7/2024 reflects, "(R49) was referred to into the emergency department today due to progressive			

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	weight gain, noting a weight of 196 pounds, and a previous weight of 167 pounds on 3/21/2024. Patient seen by primary care at (facility) noting increased peripheral edema, Lasix increased from 20 mg to 40 mg. Patient also describes shortness of breath with activity and orthopnea (discomfort when breathing while lying down flat)...In the emergency department, patient was noted to have clinical evidence of anasarca (extreme generalized edema or massive edema). BNP (Brain Natriuretic Peptide, a measure of heart function) is elevated 785 (normal range for BNP is less than 100 picograms per milliliter pg/mL). Chest x-ray shows progressive pulmonary edema with increasing bilateral pleural effusions."			