Unchanged for Hours

The nursing home failed to provide sufficient staffing to respond to call lights in a timely manner as expressed by residents in a confidential group meeting. The nursing home also failed to provide sufficient staffing to ensure provision of incontinence care and personal hygiene for resident 2. The deficient practice resulted in actual unmet care needs including residents soiling themselves when staff were untimely in response and actual unmet care needs for resident 2.

Six residents with intact cognition (BIMS score 15 out of 15) met in a confidential group meeting. Resident 2 stated there was a long wait for assistance to use the bathroom. She said that staff "don't care if you have to go right now. It makes me mad...I have had accidents (incontinence)" and "The facility needs more staff" but "Corporate doesn't give you more staff. They just take (admit) more residents."

The six residents in the confidential group meeting agreed that they usually had to wait at least 30 minutes for help after a call light was pressed. Resident 1 said, "Staff would come to the bedroom after 30 minutes had passed and would turn off the lights and say, 'Oh, we will be back,' and they do not ask you what you need. They don't come back." Resident 3 agreed the nurse aides turn the call light off and do not help. She added, "I have had an accident (soiled herself) quite a few times." Resident 1 said that after pushing the call light at 6:00 PM, she did not receive help until 4:00 AM. She added that she has had many days when after waking up in the morning she was not changed until 2:00 PM in the afternoon.

The residents expressed concerns of retaliation and wished to remain anonymous.

During an interview, Contracted Therapist L who provided services to residents at all hours of the day and night found that staffing was an issue. She revealed, "I have seen call lights be on for hours. Long waits were the case particularly for those residents who needed two staff members for transfers." On the evening shift, she often observed only one nurse aide working per hall and one nurse working between two halls. She said that she has seen residents "have to wait more than six hours." She said she has timed the call light response time and estimated the average wait time for residents who needed two staff members to help transfer was two hours. She stated that she has seen residents "have the call light on at night and have to wait until the day shift comes in to be changed." She added, "If residents need to be changed or need water, it is low priority" and that sometimes there are eight lights going off and only one staff member present.

The surveyor's observations of resident 2 (e.g., leaking catheter; soiled bedsheet), review of staffing records, and interviews with staff provided support for the residents' concerns. For example, Medical Records Staff R acknowledged that on many days there were entire shifts or spans of hours where there were no CNAs or Nurses assigned to the care units.

Name of Nursing Home	Autumnwood of McBain / Provider ID: 235438
Address	220 Hughston Street, MC Bain, Michigan
Date investigation completed	March 1, 2022
Type of deficiency issued	F725 – Sufficient Nursing Staff
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235438/health/standard?date=2022-03-01