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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235020 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Michigan Masonic Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Wright Ave Alma, MI 48801 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>29073</p> <p>Based on observation, interview and record review, the facility failed to maintain self-esteem, honor preferences and ensure care was given in a dignified manner for one resident (R47) out of 22 residents reviewed for dignity.</p> <p>Findings:</p> <p>Review of an Admission Record reflects R47 admitted to the facility with diagnosis that included Parkinsonism (a group of movement disorders that share similar symptoms to Parkinson's disease), difficulty walking, unspecified mood disorder, anxiety and agoraphobia (fear of places and situations that might cause panic, helplessness and embarrassment) with panic disorder.</p> <p>During an observation and interview on 12/16/24 at 10:31 AM, R47 was in a maroon-colored t-shirt and athletic shorts. The t-shirt was soiled with what appeared to be food spills, a crucifix around his neck was caked with an unknown substance. R47 reported his breakfast spilled the day before and no one came to help him clean it up.</p> <p>During an observation and interview on 12/17/24 at 9:07 AM, R47 was wearing the same soiled clothes he had on the day before. R47 reported that he does not like his showers because he does not like showers given to him by women. R47 said that he would be more willing to shower if a male attendant helped him. R47 repeated that women showering him was not appropriate and embarrassed him.</p> <p>During an interview on 12/17/24 at 9:13 AM, Registered Nurse (RN) N reported she was aware R47 did not like women showering him. RN N said R47's preference to have male caregivers is not care planned, but there is a male Certified Nurse Aide (CNA) who could help if needed and the facility should be able to accommodate this need.</p> <p>Review of a Task Monitor for showering and bathing for the last 30 days (11/22/2024-12/16/2024) reflected R47 had one shower on 11/22/2024 with Set-up or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. The report showed that R47 refused a shower on 11/25/2024 and 12/10/2024. The report showed Not Applicable on 12/2/2024 and 12/16/2024.</p> <p>(continued on next page)</p> |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of a Care Plan initiated on 2/25/2021 reflected R47 required assistance with ADL (activities of daily living), mobility and toileting. Interventions and tasks related to this focus included BATHING supervision x 1 (one assist) as I allow. The care plan did not specify R47's preference for male caregivers. Further review of the entire care plan revealed R47 was taking psychotropic medications for depression, anxiety and agoraphobia with fluctuating symptoms of anxiousness. The care plan did not include interventions to address R47's reported embarrassment with female caregivers and preference for male caregivers for showers.</p> <p>During an interview on 12/18/2024 at 11:54 AM, Registered Nurse (RN)/Assistance Director of Nursing (ADON) O reported that she was very familiar with R47 and knew he did not like women giving him showers. RN/ADON O said the staff needed to do a better job of documenting R47's refusal to shower and attempts to reapproach when needed. RN/ADON O said there is a male CNA who could accommodate R47's preference for male caregivers when showering.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101</p> <p>Based on observation, interview and record review, the facility failed implement interventions to prevent falls for three residents (R12, R38, and R87) of 6 residents reviewed for falls.</p> <p>Finding include:</p> <p>Resident #87 (R87)</p> <p>Review of R87's face sheet dated 12/18/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Dementia, pain and edema. He was not his own responsible party.</p> <p>Review of his Brief Interview of Mental Status (BIMS) score dated 9/24/24 revealed a score of 2/15, indicating he is severely cognitively impaired.</p> <p>R87 was observed on 12/16/24 at 11:01 AM in his room in a recliner chair with his feet up and not supervised. A couple minutes later, R87 was observed walking by himself in his room to the bathroom with no assistive device. A few minutes later, he was observed walking back to his recliner alone.</p> <p>During an observation and an interview on 12/17/24 at 3:00 PM, R87 was in his room in a recliner alone with his feet up. No walker was observed in his room. Registered Nurse (RN) C came to the resident's room and was asked about how much assistance R87 needed for ambulation. RN C reported he required a walker with one person to assist for ambulation.</p> <p>Review of R87's incident report dated 12/6/24 at 5:50 AM revealed he had a witnessed fall in his room. The CNA (Certified Nursing Assistant) was in his room at the time to take him to the bathroom.</p> <p>Review of R87's Fall Root Cause Summary dated 12/10/24 at 14:40 (2:40 PM), for the fall that occurred on 12/9/24, revealed he was last observed in bed at midnight and was dry at that time. (3 hours and 17 minutes prior to being found on the floor in the hallway). Interventions included: assist to the bathroom every 2 hours while awake (standard of care), gripper strips to the floor by the bed, gripper strips to the floor in front of recliner, keep in supervised area while up and therapy to screen due to weakness. There was no indication that supervision when awake was implemented.</p> <p>Review of the Fall Root Cause Summary dated 12/9/24 at 17:07, for the 12/6/24 fall for R87 revealed he was last observed at 5:50 AM, last time toileted 2:00 AM. Summary of incident. Resident was standing up from recliner to go to the bathroom with staff in room at the time. Resident became weak and went to his knees. Resident did not hit his head. Abrasion LT (left) knee. Intervention: Remind and encourage me to use my call light as needed during acute illness.</p> <p>Review of R 87's incident report dated 12/9/24 at 3:17 AM revealed R87 had an unwitnessed fall in the hallway. Interviews revealed he was confused but did not indicate other behaviors or give details about amount of sleep or any routine patterns of care that were the same or different that night.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of R87's fall care plan revealed he is at high risk for falls due to dementia, pain, history of falls, incontinence, poor safety awareness and self-transfers often, dated 9/19/24. The fall interventions included keep in supervised area while up, initiated on 12/9/24. (Which is not reflected on the Kardex).</p> <p>Review of R87's Kardex dated 12/18/24 revealed that he was to be assisted to the bathroom every 2 hours while awake, he was not to be left unattended in the bathroom, he was to use a front wheeled walker with limited assistance of one person to walk. There was no intervention for him to be in a supervised area while he is awake. (This intervention was on the care plan).</p> <p>Resident #12 (R12)</p> <p>Review of R12's face sheet dated 12/18/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Vascular dementia, sleep apnea, and unsteady on feet. She was not her own responsible party.</p> <p>During an observation and an interview with Registered Nurse (RN) C on 12/17/24 at 2:49 PM she pointed out R12 in the main dining area on the unit playing bingo at that time. She confirmed that R12 was a fall risk, and they try to keep her in supervised activities.</p> <p>Review of R12's incident and accident report dated 9/27/24 at 11:12 AM revealed R12 had a witnessed fall in the day room. The Certified Nurse aide reported R12 was self-transferring and noticed R12's knee was shaking. The report said R12 used the toilet at 8:30 AM and was last seen in the day room [ROOM NUMBER] minutes prior to the fall. The report did not indicate any activity was happening at the time of the fall or provide any details of care provided or behaviors.</p> <p>Review of R12's Fall Root Cause Summary dated 10/1/24 at 16:13 (4:13 PM) for the fall that occurred on 9/27/24 revealed R38 was seen sitting in a chair in the sunroom [ROOM NUMBER] minutes prior to being found on the floor. The summary of incident revealed, Resident was self-transferring to the bathroom in the day room when her leg knee gave out. Staff had observed her transferring and not asking for help. Due to her cognition resident does not always remember to ask for assistance. Intervention placed was a bell provided in day room when sitting in day room to ring for help.</p> <p>Review of R12's incident report dated 10/7/24 at 10:58 AM revealed R12 had an unwitnessed fall in the sunroom. R12 indicated that she needed to use the bathroom. She was last observed at 10:30 AM sitting in the sunroom with her eyes closed. R12 did not use the bell. The report did not indicate when she was last assisted to the toilet. The report did not indicate any activity, or supervision was being provided at the time of the fall. No interventions placed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of R12's Fall Root Cause Summary dated 10/15/24 for the fall that occurred on 10/7/24, revealed R12 was observed sitting in a recliner in the sunroom with her eyes closed at 10:30 AM, she had tennis shoes with grip and had a walker in use at that time. Summary of incident, Resident observed on the floor in sunroom in front of sunroom chair. Resident stated she was attempting to get up and use the bathroom when her right leg gave out. Resident did not use her bell provided to ask for assistance. Resident does have a history of self-transfers and d/t cognition does not always ask for help. Interventions placed, assist to common area when up, dycem placed in in chair in sunroom, Therapy to focus on transfers for the chairs in the sunroom. One person assists on and off the unit. Previous intervention was to provide a bell in the sunroom. Previous fall was also in sunroom, providing a call bell was not effective for a severely cognitively impaired resident. There was no indication that the dycem would prevent self-transfer and no indication of how they would be addressing the unsafe transfers or meeting her toilet needs.</p> <p>Review of R12's fall care plan dated 4/23/24 revealed that R12 was high risk for falls related to dementia, history of falls, unsteady on feet, poor safety awareness, and history of self-transfers. She has been noted to rush when she is walking and needs to be reminded to slow down. She is on diuretic, seizure and psychotropic medications. She has seizure like activity. She uses a walker to walk. She has occasional incontinence and sometimes takes herself to the bathroom. Interventions included: assist me to common area when up 10/7/24, Dycem (nonskid material) in chair in the sunroom where she enjoys sitting most days. Provide bell in day room when I am sitting in there 9/27/24, Therapy to focus on transfers from the chair in the sunroom.</p> <p>Resident #38 (R38)</p> <p>Review of R38's face sheet dated 12/18/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Alzheimer's disease, chronic kidney disease with heart failure. She was not her own responsible party.</p> <p>Review of R38's Minimum Data Set (MDS) nursing assessment dated [DATE] revealed she was severely cognitively impaired.</p> <p>Review of R38's incident report dated 7/14/24 at 15:30 (3:30 PM) revealed she had an un-witnessed fall in the dining room near her wheelchair. Review of R38 fall care plan revealed no new fall intervention was placed after this fall.</p> <p>Review of R38's Root Cause Summary dated 7/16/24 at 13:34 (1:34 PM) for the fall on 7/14/24 revealed the same information that was on the incident report dated 7/14/24 at 3:30 PM. The new intervention placed was pain cream was discontinued, and a pain patch started, therapy screen for strengthening and she was referred to a physician for increased behaviors. No documentation was located that indicated R38 had signs/symptoms of pain prior to the fall. The documentation did not include any behaviors prior to the fall. It was not clear why pain and behaviors were determined to be the root cause of her fall.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of R38's incident and accident report dated 7/30/24 at 17:30 (5:30 PM) revealed she had an unwitnessed fall in the hallway. Staff statements revealed she had been in bed at 4:00 PM and she refused to use the bathroom at that time. She had shoes on. When R38 was asked what she was doing she said she slid out of bed and scooted in the hallway. There was no indication how long she had been in bed, when was the last time she used the toilet, or how she had responding to care earlier that day. (or when her needs were last met).</p> <p>R38's Fall Root Cause documentation for fall on 7/30/24 dated 8/6/24 at (7 days after the fall). New interventions were blood sugar checks before meals for 1-day, orthostatic blood pressures for 3 days and bowel and bladder monitoring for 3 days. There were no meaningful or sensical interventions to address or prevent future falls based on investigation.</p> <p>Review of R38's incident and accident report dated 10/11/24 at 20:25 (9:25 PM) revealed R38 had an unwitnessed fall in her room. Staff statements revealed R38 was watching TV at 19:30 (8:30 PM) in an unknown location. No information was documented that provided to indicate what R38's behaviors were that day, when she went to bed, how long she slept or the last time she had used the toilet. New interventions work order for gripper strips in front of the recliner and bed.</p> <p>Review of R38's Fall Root Cause dated 10/17/24 at 17:03 (5:03 PM) regarding the fall on 10/11/24 revealed that R38 was in her recliner watching TV at 19:30 (approximately 1 hour prior to her fall). There was no indication of the last time she used the bathroom, behaviors prior to the fall, when she slept last. There was no indication of any changes in condition or behavior noted. The new intervention placed was gripper strips in front of the recliner and side of bed. Not enough information provided to show a thorough investigation of a fall to show gripper strips as an appropriate intervention.</p> <p>Review of R38's incident and accident report dated 11/14/24 at 2:45 AM revealed she had an un-witnessed fall in her room, she was on the floor in front of the bathroom, her walker was in the bathroom and her shoes were on the opposite feet. They moved her closer to the nurse's station for observation. Staff statements revealed R38 was seen 45 minutes prior to the fall, sleeping in bed. No indication of how long R38 had been sleeping prior to the fall.</p> <p>Review of R38's Fall Root Cause dated 11/18/24 at 17:00 (5:00 PM) for the 11/14/24 fall revealed R38 used the toilet at 12:31 AM. No indication of behaviors, sleep pattern or amount of time resident had been sleeping was found. Under interventions was offer, encourage an assist me to the bathroom every 4 hours (old intervention and according to the root cause was provided that night.) No new interventions were located.</p> <p>Review of R38's Kardex (care giver instructions) dated 12/18/24 (date of this survey) included the following information in the safety section: do not leave me unattended in my bathroom, offer, encourage and assist me as need to the bathroom every 4 hours, and when I am awake in the night and ambulating, assist me to the common area. Mobility included: ambulation extensive assist x 1 using 4 wheeled walker, bed mobility independent, toilet use extensive assist of 1 encourage, offer, and assist with toileting before and after meals and at bedtime. Transfer extensive assist of 1 with 4 wheeled walker.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of R38's Activities of Daily Living (ADL) care plan dated revision on 11/19/24 revealed, I will frequently attempt to self-transfer and ambulate on my own. I have poor safety awareness and do not utilize my call light consistently. I have a history of declining the use of a gait belt. I choose not to consistently use my walker in my room. I prefer to sleep in at times and may yell at staff and become combative with cares.</p> <p>Review of R38's fall care plan dated revision on 12/17/24 revealed that R38 has had a history of falls, frequently does not use her walker and takes medications that can alter her balance. She had poor safety awareness and is impulsive. She had a history of using furniture in her room to walk, laying on the floor in her room. She is taking diuretic medication (causing urination). She can be resistive and combative with care. On 3/23/23 the intervention to take R38 to the common area when she is awake and at night when walking was added.</p> <p>During an interview with Unit Manager A on 12/18/24 at 9:00 AM, Unit Manager A was asked about the process of coming up with new interventions and what were the new interventions placed for R38 on 7/14/24 and 7/30/24. Unit Manager A used the electronic medical record to review R38's care plan and fall documents. She could not locate new interventions or information on how they determine the interventions.</p> <p>Unit Manager A called the Assistant Director of Nursing (ADON) and the ADON came and started reviewing the record for resolved care plans as she could not locate a new intervention in the current care plan. The Director of Nursing joined the interview and explained that they do an initial meeting with staff and document what happens. They take that information and do a Root Cause Analysis. They are to place interventions at the time and add interventions based on the Root Cause Analysis.</p> <p>The surveyor requested the Root Cause Analysis documentation of this process for: R38, R13 and R87. It was not clear how the facility was going to improve safety or supervision of these residents as they were all severely cognitively impaired, were known to not use call lights, known to self-transfer and had poor safety awareness.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p>38905</p> <p>Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the residents in the facility. Findings include:</p> <p>During a tour of the main dry storage area for the kitchen, at 11:38 AM on 12/16/24, an interview with Life Safety Emergency Manager (LSEM) K and Director of Dining Services (DDS) M found that this area is no longer used for its intended purpose of being a serving kitchenette. Observation found multiple water fixtures including a preparation sink, a hand sink, a steam table fill, and pot fill fixture on the cook line, that had been stagnant and not under any routine flushing schedule. Sink compartments were found covered, dry and dusty. The hot and cold water lines for the kitchenette hand sink was turned on and brown water came out momentarily before turning clear.</p> <p>During a tour of the first floor North Kitchenette, starting at 11:54 AM on 12/16/24, an interview with DDS M found that dietary staff don't use the back dish room portion of the first-floor kitchenette. When asked if this area is on a regular flushing schedule for removing stagnant water, LSEM K stated that they will add this area to the list.</p> <p>During a review of the facilities Water Management Plan (WMP), starting at 1:40 PM on 12/16/24, with DDS M, LSEM K, Director of Facilities (DOF) J, and Director of Environmental Services (DES) I, an interview with staff found that they do regular flushing of water as part of their risk prevention. When asked if the facility currently sent anything to a lab for testing or if they did any testing in house, DOF J stated that they currently do not. When asked if there was any other control measures or limits the facility was using to decrease the risk of Legionella or other OPPP, staff were unsure.</p> <p>During a tour of the facility, at 3:10 PM on 12/16/24, it was observed that a janitors closet on the second floor North hall, was found with a faucet and no chemical pre dispense. When asked if staff use this sink, DES I asked EVS Aide L and he stated, nobody ever uses that sink. When asked if this was a fixture that is routinely flushed, LSEM K stated they would add it to the list.</p> <p>During a tour of the Ventilation Unit, at 3:10 PM on 12/16/24, it was observed that a water line that used to service the flush valve of a hopper, was protruding from the wall with crusted debris residue on the outside indicating it was still servicing water and was a stagnant line. An interview with DOF J found that he was unsure if the water line had been disconnected or if it was a stagnant line.</p> <p>A record review found an Infection Control Risk Assessment, dated 11/30/17, with no facility layout or instructions on how water flows through the facility.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>A review of the Michigan Masonic Home Water Management Program Procedure, revised 09/2024, found that .3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the Homes water system. The risk assessment will consider the following elements: a. Premises plumbing: This includes water system components as described in the documentation of the Homes water system .</p> <p>A review of the Michigan Masonic Home Water Management Program Policy, revised 9/2024, found that 3. Based on the risk assessment, control points (locations in the water systems where a control measure can be applied) will be identified. 4. Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfection level control, visual inspections, or environmental testing for pathogens. 5. Testing protocols and acceptable ranges (control limits) will be established for each control measure.</p> | | |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>38905</p> <p>Based on observation and interview the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination, affecting residents, staff, and the public. Findings Include:</p> <p>During a tour of the kitchen, at 11:15 AM on 12/6/24, observation of the dish machine area found that the dirty side of the machine had a roughly 10 foot long built in rinse stream, that drains into the garbage disposal. The rinse stream had multiple submerged inlets that hang below the overflow rim of the rinse table and was not observed with an atmospheric vacuum breaker (AVB) that would protect the potable water supply from potential back siphonage (due to the submerged inlets). An interview with Director of Facilities (DOF) J found that he has only been here a couple months and was not sure if the submerged inlets were protected with an AVB. When asked if he could see an AVB anywhere in line of the submerged inlets, DOF J sated he could not.</p> <p>During a tour of the first floor North clean holding room, at 2:18 PM on 12/16/24, it was observed that a mop sink faucet was found left on and connected to a chemical pre-dispense. No wasting tee or sidekick device was present to remove constant back pressure from the faucet's internal AVB. An interview with Director of Environmental Services (DES) I found that the faucet should be shut off between use.</p> <p>During a tour of the second floor North spa room, at 2:40 PM on 12/16/24, it was observed that a stack of towels and wash cloths were found stored open and exposed next to the shower. An interview with Life Safety Emergency Manager K found that linens should not be stored open and exposed.</p> <p>During a tour of second floor North, at 2:45 PM on 12/16/24, it was observed that the tabletop ice machine was found directly connected to the wastewater drain. Food contact equipment must be air gapped in order to remove the risk of contamination due to wastewater back flow.</p> <p>During a tour of the Ventilation Unit spa room, at 2:55 PM on 12/16/24, it was observed that four towels and six wash cloths were found stored open and exposed next to the shower.</p> <p>During a tour of the Ventilation Unit soiled utility room, at 3:09 PM on 12/16/24, it was observed that a mop sink faucet was found installed over an area where a hopper used to be installed. At this time, no wastewater access was available for this water fixture and water would run down onto the floor.</p> <p>During a tour of the laundry room, at 3:30 PM on 12/16/24, it was observed that one of the clean laundry carts was found with an accumulation of paper trash and debris under the carts false bottom.</p> | | |