STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235028	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron CO Med Care Facility	1116 S Van Dyke Rd Bad Axe, MI 48413

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37666 Based on observation, interview and record review, the facility failed to ensure residents were treated in a dignified manner for a Confidential Group of residents, from a group of 28 residents reviewed for dignity, resulting in residents having soiled briefs due to call lights not being answered timely, a lack of a functional outdoor patio, and no opportunity to spend their Bingo winnings due to a closed Bingo store. Findings Include: FACILITY On 7/09/24 at 2:03 PM, during a meeting with a Confidential Group of Residents, several residents on the 2nd and 3rd floors said on the 3rd shift (night shift), their call lights were not being answered timely. They said staff members would come in to answer the call light, but would turn off the call light, sometimes they would ask them what they needed and sometimes they would not, the staff would leave the room and usually not come back in to help them. Three residents said there were occasions when the staff member did not come back to assist them to the bathroom and the residents soiled themselves. The residents said they don't understand why the call lights are not answered because, if it rings for too long, the signal is sent to a supervisor. They said sometimes it takes 1 hour for someone to come in to answer the call light. During the interview on 7/9/2024 at 2:03 PM, the Confidential Group of Residents voiced concerns that the Bingo store was closed and removed. They said many residents like to play Bingo and when they won, they could use their winnings to shop at a store that was set up in the facility that had a variety of items for them to buy. The residents said the facility was going to use the area housing the Bingo store for something else, and said they would find a new location for a Bingo store for them. The residents said it had been several months and there was no solution. The residents said this was a hardship for them because the store had many items that they felt they needed and wanted to buy. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/9/2024 at 2:20 PM, during the interview with the Confidential Group of Residents, they said they were upset and discouraged because it was now July and the outdoor patio had not been cleaned and the table and chairs were not set up for use. They said they had a garden out there, but there was no nozzle on the hose to water the plants- tomatoes, peppers and cucumbers that they had planted. They said they could not have visitors on the patio because it was not presentable. The residents said they were very concerned, because they were supposed to have a scheduled activity outside on the patio Thursday or Friday of that week and the patio was not ready. The resident's said they felt disrespected because if it was someone's home patio, they would have cleaned it up in the Spring and now it was Summer and still not done. On 7/10/2024 at 9:45 AM, during a tour of the outdoor patio, it was observed that the tables and chairs were all clustered together near the building, except for one table with two chairs around it. The patio was large with enough space to accommodate many people. The resident's plants were observed, and the hose was laying on the ground in the middle of the patio near the plants. On 7/10/2024 at 2:30 PM, the Administrator was interviewed about the Confidential Group of Resident's concerns. She said she was not aware of their concerns about the call lights not being answered timely on the night shift. However, the Administrator said she was aware of the Bingo store being taken down. She said the facility was planning to reopen it somewhere else in the building, on July 23, 2024. Discussed with the Administrator that this meant a lot to the residents and they were not aware of a date to open the Bingo store, or why it was taking so long. They really enjoyed Bingo and spending their Bingo winnings in the Bingo store. During the interview with the Administrator on 7/10/2024 at 2:30 PM, she was asked about the outdoor patio, she said the plan was to set up the patio, but it had not been set up because a storm was coming in. Reviewed with the Administrator that it was now July, and the facility had several months to prepare the patio for resident and visitor use and had not done so. She said she was going to meet with the maintenance department and develop a plan to have the patio ready. A review of the document by the Consumer Voice, Washington DC, Nursing Home Resident's Rights, provided the following: Residents of nursing homes have right that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to promote and protect the rights of each resident and stresses individual dignity and self-determination . Right to a Dignified Existence: Be treated with consideration, respect, and dignity, recognizing each resident's individuality . Quality of life is maintained or improved . A homelike environment .

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 37666 Based on observation, interview and record review the facility failed to effectively act upon repeated concerns from the facility's Resident Council and one resident (Resident #28) of 28 residents reviewed, resulting in resident frustration and anger that their concerns were not being addressed for 1) Call lights not being answered, 2) Food preferences and cold food, 3) The inability to entertain on the outdoor patio and 4) Removal of the Bingo store. Findings Include: FACILITY Resident Council On 7/09/24 at 2:03 PM, during a meeting with 18 members of the Resident Council, they said they were upset because their concerns were not being addressed. They said they bring their issues and concerns to the Resident Council meetings each month, but they do not feel anyone is listening or trying to resolve their issues. A review of the Resident Council meeting minutes, approved for review by the Resident Council President, identified the following: January 30, 2024 with 18 residents in attendance: Residents voiced they would like a staff member to stay with them on the independent side of the dining room during meals to help them if they needed it. February 27, 2024 with 15 residents in attendance: Residents voiced concerns that staff were not coming back when they said they would/call lights. The Registered Dietitian attended and reviewed an Always Available menu that the residents could order from and it would start soon. March 26, 2024 with 11 residents in attendance: Residents would like food to stay longer on the floor in case the wanted seconds; April 29, 2024 with 20 residents in attendance: Residents voiced concerns about room temperatures at night; When will the Bingo store open and where will it be. May 28, 2024 with 17 residents in attendance: Residents voiced concerns about dinner not being as good as breakfast or lunch and vegetable concerns; When will the Bingo store open and where will it be located- The Activity Director said she would open the Bingo store the next week (week of June 3-June 7th, 2024. This did not happen.) June 25, 2024 with 13 residents in attendance: Residents voiced concerns that the kitchen was closing at times, in the evening before everyone received their meals; dinner meals were not as good as breakfast and lunch; they wanted to know when the Bingo store was opening and where it will be located. The Activity Director said she would open it the following week in the Activity room (week of July 22-26, 2024: this did not happen- note dated 7/3/2024 said it would open 7/23/2024). (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Counsel was interviewed on 7/9/2024 at 2:03:PM. Several of the residents on the 2nd and 3rd floors said on the 3rd shift (night shift), their call lights were not being answered timely. They said staff members would come in to answer the call light, but would turn off the call light, sometimes they would ask them what they needed and sometimes they would not, the staff would leave the room and usually not come back in to help them. Three residents said there were occasions when the staff member did not come back to assist them to the bathroom and the residents soiled themselves. The residents said they don't understand why the call lights are not answered because, if it rings for too long, the signal is sent to a supervisor. They said sometimes it takes 1 hour for someone to come in to answer the call light. During the meeting with the Resident Council on 7/9/2024 at 2:10 PM, the resident voiced concerns about the Meals: Breakfast usually pretty good, lunch fair to good, supper is a different cook, sometimes good sometimes not; Alternate list for meals did not happen; you cannot have a hamburger at any time unless they know around lunch time for supper or the night before same with chef salad. Gluten diet accommodated to a certain point, not enough choices. Mushy vegetables at times; food cold sometimes; Sunday morning cheese omelet cold, dry, and the cheese was not melted. The resident said they had a Food council once or twice and a suggestion box was placed on the dining room wall. Not everyone can use it. Residents said sometimes they were not served a food item that was on the menu, but other residents would receive it. They said that week they were told there were no more sugar cookies and some residents did not receive one while other residents did. They said this had happened in the past also and they were very upset that some residents received the food they were supposed to receive and others went without. Someone from the Dietary department attends the Resident Council meetings. They do not seem to address the concerns. During the interview on 7/9/2024 at 2:03 PM, the Confidential Group of Residents voiced concerns that the Bingo store was closed and removed. They said many residents like to play Bingo and when they won, they could use their winnings to shop at a store that was set up in the facility that had a variety of items for them to buy. The residents said the facility was going to use the area housing the Bingo store for something else, and said they would find a new location for a Bingo store for them. The residents said it had been several months and there was no solution. The residents said this was a hardship for them because the store had many items that they felt they needed and wanted to buy. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/9/2024 at 2:20 PM, during the interview with the Confidential Group of Residents, they said they were upset and discouraged because it was now July and the outdoor patio had not been cleaned and the table and chairs were not set up for use. They said they had a garden out there, but there was no nozzle on the hose to water the plants- tomatoes, peppers and cucumbers that they had planted. They said they could not have visitors on the patio because it was not presentable. The residents said they were very concerned, because they were supposed to have a scheduled activity outside on the patio Thursday or Friday of that week and the patio was not ready. The resident's said they felt disrespected because if it was someone's home patio, they would have cleaned it up in the Spring and now it was Summer and still not done. On 7/09/24 at 2:58 PM, the Activities Director L was interviewed. She said she was new in her role and started about 3 weeks prior. She said she had attended one Resident Council meeting on 6/25/24. She said she was aware of the resident's food and Bingo store concerns. She said she wasn't sure about the food concerns, but she was aware of the Resident's being upset about the Bingo store. She said there had been discussion about setting up the store, but it hadn't been done yet. During the interview, the Activities Director L was also asked about the resident's food concerns, she said she had heard about some of their concerns, but was not aware what was being done for them. She was asked if the resident's concerns identified in the Resident Council meetings were being addressed. The Activities Director said the concerns were to be placed on a form Council Concern/Recommendation Form that was then forwarded to the appropriate Manager for a response and then they returned the form to activities with the action they identified to fix the issue. The Activities Director was asked if she had copies of the forms addressing the residents' issues. She said she had the forms. Copies of the forms was requested at that time. One Council Concern/Recommendation Form was received; it was dated 5/10/2024 and provided: To: Dietary Manager (A), Concern: Residents are concerned about meal temps being cold. Please return to the Council by: Date 5/10/24, Name: (Activities Director); Staff Response: (Dietary Manager) reminded staff on temping meals and following temp logs. Educated staff at huddles. The Staff Signature, Date and Implementation Dates were all blank. On 7/10/2024 at 9:45 AM, during a tour of the outdoor patio, it was observed that the tables and chairs were all clustered together near the building, except for one table with two chairs around it. The patio was large with enough space to accommodate many people. The resident's plants were observed, and the hose was laying on the ground in the middle of the patio near the plants. On 7/10/24 at 9:53 AM, Dietary Manager A was interviewed about the residents' concerns that were being mentioned in 4 of the last 6 Resident Council meetings related to cold food, quality of the food, especially the evening dinner meal, assistance with meals and food preferences. The Dietary Manager said he had heard these concerns in the past, but didn't think it was still an issue. Reviewed with the Dietary Manager that the residents were upset about this at the Resident Council meeting on 7/9/2024 and said this was still happening. The Dietary Manager was asked about Resident specific dietary needs such as a Gluten free diet. He said there was only resident with a gluten free diet and he said he had never met with the resident 1:1 to see what she would she would like. He said the cakes the facility makes are not gluten free, but they have an Oreo type cookie. He said he did not know what the resident liked. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked about residents not receiving menu items because the resident is told the facility ran out, he said sometimes a floor didn't have a food item, but they could try to get it from the kitchen or another floor. He said he had not seen a grievance form related to food, and he started at the facility in February 2024. When reviewing the residents' concern about the evening meal, he said he was aware, but said no intervention was enacted to correct this. On 7/10/2024 at 2:30 PM, the Administrator was interviewed about the Confidential Group of Resident's concerns. She said she was not aware of their concerns about the call lights not being answered timely on the night shift. However, the Administrator said she was aware of the Bingo store being taken down. She said the facility was planning to reopen it on July 23rd, somewhere else in the building. Discussed with the Administrator that this meant a lot to the residents. They really enjoyed Bingo and spending their Bingo winnings in the Bingo store. The residents said they had been told several previous times that the Bingo store would open and it did not. During the interview with the Administrator on 7/10/2024 at 2:30 PM, she was asked about the outdoor patio, she said the plan was to set up the patio, but it had not been set up because a storm was coming in. Reviewed with the Administrator that it was now July, and the facility had several months to prepare the patio for resident and visitor use and had not done so. She said she was going to meet with the maintenance department and develop a plan to have the patio ready. The Administrator was asked about the residents' concerns with food and she said the Dietary department was trying to work on the issues and would continue to try and find a solution, A review of the facilities policies identified the following: Activities, date implemented 1/9/2023 and revised 1/16/2024, It is the policy of this facility to provide an ongoing program to support residents in their choices of activities based on their comprehensive assessment, care plan, and preferences . Call lights: Accessibility and Timely Response, date implemented 04/2023 and revised 03/2024, The purpose of this policy is to assure the (facility) is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified . Accommodation of Food Needs, issues 5/1/2019, revised 5/3/23 and reviewed 7/10/2024, Reasonable accommodations will be made by the culinary Department to those patients/residents with food preferences . Dietary Department Objectives, issues 5/1/2019, reviewed 11/1/22, The purpose and scope of the Dietary Department is to provide a program that meets the nutritional needs of all residents/patients . Consideration is given to the patients' physical, psychological and social needs. Recognition is also given to the patient's individual eating habits . Procurement and production of food products is to be carried out to ensure the patient a sufficient quantity of wholesome and nourishing food of acceptable variety and quality . (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident and Family Grievances, date implemented 05/2008 and date reviewed/revised 2/29/24, It is the policy of this facility to support each resident's and personal representative's right to voice grievances, . without discrimination, reprisal or fear of discrimination or reprisal . Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance . 49944 Resident #28 (R28): On 07/08/24 at 11:45 AM, an interview was conducted with R28. R28 stated that they have some issues with the activity program. R28 stated that they used to have a bingo store and when you won a game of bingo you would get points. R28 stated you can redeem those points for goodies such as snacks, clothes or toiletries. R28 stated the facility closed the store about 6 months ago and have not reopened it yet, they were told the facility was doing construction in the room for staff. R28 said the store is still not open and that the residents of the building really look forward to playing bingo and going to the store. This surveyor then asked R28 if there were any other concerns they wanted addressed. R28 said that the outdoor patio area used to be lovely with lots of tables, umbrellas and a fountain that was running. R28 stated the fountain isn't set up, there are no umbrellas, the tables are dirty and the whole area is a disaster. This surveyor asked R28 if they had been on the patio at all this spring or summer and they said no. R28 said you only get so many months of nice weather in Michigan, it's a shame we can't go out there. R28 thanked this surveyor for their time and for looking into the concern. On 07/08/24 at 12:00 PM, an observation revealed the patio area had a fountain that was not functioning, no umbrellas, no cushions and all of the chairs and tables were pushed up against the building. On 07/09/24 at 01:56 PM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA was asked when the bingo store closed. The NHA stated the bingo store closed in April 2024 for remodeling. The NHA was asked when the store is going to reopen? The NHA stated they remodeled the bingo store area to become an area for staff and that the new store would be in a different location and opening on July 23, 2024. On 07/09/24 at 01:59 PM, the NHA was asked about the outdoor patio area and why it was not being utilized. The NHA stated that R28 brought the concern to them last week and the NHA told the maintenance department to get new umbrellas and new cushions for the area.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to develop a baseline care plan for falls for one resident (Resident #24) of 28 residents reviewed for baseline care plans resulting in an incomplete baseline care plan and the resident sustaining falls. Findings include: Resident #24 (R24): Resident #24 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include epilepsy, depression and profound intellectual disabilities. On 07/08/24 at 01:16 PM, record review of the 802 revealed that R24 triggered on the report for falls in the facility. On 07/09/24 at 12:23 PM, record review revealed R24 had sustained falls on 05/22/24 and 07/04/24. On 07/09/24 at 12:27 PM, record review revealed R24 had a baseline care plan for falls that was dated 05/17/24, R24 was admitted to the facility on [DATE]. Record review revealed that R24 was assessed for fall risk on 05/14/24 and was a high risk for falls with a score of 22, anything higher than a score of 16 is high risk. A baseline care plan for falls was not implemented until 05/17/24, this was verified by Minimum Data Set Nurse (MDS) N, MDS N nurse was asked when the baseline care plan should be completed and they said within 48 hrs of admission. MDS N nurse was asked if falls should be addressed on the baseline care plan and they said yes. A review of the policy titled Baseline Plan of Care Summary reviewed 02/2024 revealed: Procedure: 1. The baseline care plan will: a. be developed within 48 hrs of a resident's admission. b. include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. initial goals based on admission order. ii. physician orders. iii. dietary orders. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iv. therapy orders. v. social services, vi. PASARR recommendation, if applicable. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs Including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall or pressure injury risk.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review the facility failed to develop and implement a resident-centered comprehensive care plan for one resident (Resident #134) of 28 residents reviewed for Care Plans, resulting in Resident #134 lacking a Care Plan with resident-specific interventions to address likes and dislikes. Findings Include: Resident #134: A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #134 was admitted to the facility on [DATE] with diagnoses: Alzheimer's Dementia, urinary retention, glaucoma, anxiety, depression, pain, restlessness and agitation, constipation kidney cyst, neuralgia and a history of migraines. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status (BIMS) score of 3/15 and was independent with ambulation needing supervision and supervision to assist with all care. On 7/08/24 at 3:29 PM, Resident #134 was observed wandering non-stop in the hallways and trying to go into other residents rooms. A staff member was following along with him and encouraging him not to enter other resident's rooms. The resident was wandering through the entire 300 hall. On 7/8/2024 at 3:45 PM, Clinical Coordinator G said sometimes Resident #134 would walk around nonstop for 30 hours. She said he always had a 1:1 staff member with him. She said he had been this way since admission. The Clinical Coordinator said sometimes his behavior was combative and he was difficult to redirect. She said initially he was in a room on the 2nd floor, but he wandered into another resident's room and barricaded himself inside the room. He was then moved to the 3rd floor with a 1:1 staff member. On 7/9/2024 at 12:20 PM, Social Services Director L was interviewed about Resident #134. She said the resident continuously wandered in the hallways and attempted to go into other resident's rooms or through the exit doors. She said he was assigned a private room on the 3rd floor/300 hall and a staff member was always with him, after the incident on the 200 hall/2nd floor. She said after the incident the resident was transferred to a psychiatric hospital where they attempted to stabilize his medications and then he returned to the facility. She said the plan was for him to transfer to a more appropriate Dementia unit when one became available. On 7/09/24 at 3:02 PM, Activities Director M was interviewed about Resident #134. She was asked what activities had been tried with the resident. She said someone brought in a larger toy tractor for him, because he was a farmer, to take apart and it only interested him for a few minutes; they tried walking with him and said staff rotate who provides the 1:1 with him and the Activity Aides also provided some of the 1:1's. She said he liked snacks that he could have on the go, such as a cheese stick and chocolate candies. She said they were told there were 2 movies that he liked, but he didn't seem very interested in them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview, the Activities Director was asked if Resident #134 liked older TV shows, or music from his generation. She said she didn't know. The Activities Director was asked if anyone asked the family; she said she wasn't sure. A review of the Care Plans for Resident #134 revealed the following: Most of the Care Plans were dated 7/9/2024: mood care plan started 7/9/4; mobility care plan started 7/9/24; Safety falls care plan 7/9/2024 with a high risk fall score of 16 and falls on 7/1/2024, 6/24/24, and lowered to the floor on 6/29/2024; Bladder management care plan 7/9/2024; pain care plan 7/9/24; visual function care plan 7/9/2024; Behavior care plan dated 7/9/2024; baseline care plan was dated 7/9/2024 and did not have resident centered interventions. The resident was admitted [DATE] and transferred to the hospital 6/6/2024 and returned to the facility 6/20/2024. The MDS admission assessment was completed on 7/1/2024 and the Care Plans on 7/9/2024, but the resident did not have person-centered interventions or a person- centered care plan to aid the staff in providing care to the resident. The Nutrition Care Plan was dated 6/5/2024 and was not resident specific. It did not include food likes or dislikes as referenced by the staff. The Activities Care Plan was dated 7/2/2024 and was not resident specific. There were no resident specific interventions. A review of the facility policy titled, Comprehensive Care Plans, It is the policy of the (facility) to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment . Person-centered care means to focus on the resident as the locus of control . The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to update a care plan timely for one resident (Resident #24) of 28 residents reviewed for care plan updating resulting in late care plan revision after a fall. Findings include: Resident #24: Resident #24 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include epilepsy, depression and profound intellectual disabilities. On 07/08/24 at 01:16 PM, record review of the 802 revealed that R24 triggered on the report for falls in the facility. On 07/09/24 at 12:23 PM, record review revealed R24 had sustained falls on 05/22/24 and 07/04/24. On 05/22/24 R24 sustained an observed fall, R24 rolled out of bed during morning care, no injuries were noted, the physician and guardian were notified. The Certified Nursing Assistant (CNA) was in the room providing care to the roommate when R24 was noted to roll out of bed . New intervention was to place a perimeter mattress on the bed for a tactile barrier. Fall follow up completed. On 07/04/24 at 1:45 am, a unobserved fall was sustained, neurological assessments were initiated and within normal limits, a new intervention was to place the bed in the lowest position. The physician and guardian notified on 7/4/24 of the incident, no new orders were given by the physician. On 07/09/04 an interview was conducted with Restorative Nurse O, who updates care plan interventions after an incident. Restorative nurse O was asked about the fall on 07/04/24 and when the care plan was updated. Restorative nurse O was asked who first updates the care plan after an incident, they stated that the floor nurse would enter an intervention and then they would review and update as needed. Restorative nurse O was asked when the care plan was updated for R24 after the fall on 07/04/24 and they stated it was updated on 07/09/24. Restorative nurse O was asked if that should've been updated sooner than five days after the fall and they stated yes, I am not sure how it got missed. Record review of the policy titled Fall Prevention Program, revised 02/28/2024 revealed: 6. Each resident's risk factor's and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 7. When a resident falls the facility will have: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. The interdisciplinary team team will review the resident's fall and will evaluate the need for further interventions at morning meetings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to prevent the development of a facility-acquired pressure injury and ensure timely nutritional evaluation with the development of the pressure injury for one resident (Resident #46) of three residents reviewed for pressure ulcers, resulting in a deep tissue injury to Resident #46's right heel, and the potential for lack of nutritional intervention to hasten the healing of pressure injury, and the potential of pain and discomfort. Findings include: Resident #46: A review of Resident #46's medical record revealed an admission into the facility on [DATE] with diagnoses that included heart disease, dementia, mental disorder, heart disease, diabetes and diabetic neuropathy. A review of the Minimum Data Set assessment revealed the Resident had a Brief Interview of Mental Status score of 2/15 that indicated severely impaired cognition and the Resident used a wheelchair, propelled wheelchair independently, was dependent with putting on/taking off footwear, and dependent with chair/bed-to-chair transfer. Further review of Resident #46's medical record revealed a progress note dated 4/26/24 at 5:47 AM, Incident Type: SDTI (suspected deep tissue injury) observed left lateral heel. Description of Incident: area to left lateral heel observed during skin assessment, 2.5 x 2.5 cm (centimeters) fluid filled blister with 1 x 1.3 cm purple center with surrounding blanchable redness measuring 4 x 5 cm. Progress Note dated 4/30/24 at 4:24 PM, revealed, Left medial heel, follow-up assessment, length 2.5 cm, width 2.5 cm; Tissue Type: skin intact. Fluid filled blister now intact over the SDTI. Able to visualize dark purple area under blister . Treatment: pressure injury care, cleansing and irrigation: saline; dressings: foam dressing; protective: skin/prep wipes . Interventions: support surfaces for bed; mattress; foam, support surfaces for wheelchair; cushion; foam cushions, other support surfaces: heel lifts of heel suspension device, monitor skin integrity and tissue tolerance; minimize exposure to moisture . minimize risk for shear and friction; intervention to maintain/improve nutrition & hydration status . Progress Note dated 7/2/24 at 4:31 PM, revealed, area 1: Left medial heel, follow-up assessment, length 2.2 cm, width 2.5 cm, depth: 0.1 cm, Tissue Type: partial-thickness skin loss . Current Stage: suspected deep tissue injury Healing . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Nutrition evaluations revealed a quarterly assessment dated [DATE]. The next completed nutrition evaluation after the development of the SDTI, that originated on 4/26/24, was dated 5/24/24. Comments revealed, Resident continues with no sig (significant) weight changes . PO (oral) intake averaging 75-100% most meals . Resident with new pressure area to L heel. Memo sent to UM (Unit Manager) for addition of protein Jello BID (twice a day) (20g pro, 80kcal each) as res (resident) was previously receiving this and accepts it well. Encourage protein intake to promote wound healing and meet increased protein needs (95-119g (grams) 1.2-1.5g/kg (kilograms) CBW). Cont (continue) to educate res on benefits of protein and wound healing. Cont to monitor for changes in intake/appetite and for weight trend. On 7/9/24 at 2:01 PM, an interview was conducted with Wound Care Nurse (WCN)/Assistant Director of Nursing (ADON) P regarding Resident #46's pressure injury. The WCN the origination of the DTI (deep tissue injury) was on 4/26/24 at the left medial heel area, was a dark discoloration, formed a blister, the blistered area came off revealed a pink area flush with the skin and healing. The WCN was asked if the wound was facility acquired and stated, Yes that is correct. The WCN indicated they had investigated the cause and determined it might have been caused by the foot pedals on the wheelchair, had Restorative Therapy assess the wheelchair foot pedals and placed padding on the foot pedal. The WCN indicated the Resident refused to wear anything but the grip slipper/socks, refused shoes. They started a pressure relieving boot worn at night/while in bed. When asked about nutrition evaluation, the WCN was unable to find an evaluation that was timely after the Resident had developed the pressure injury. When asked if the Dietitian had been notified of the wound, the WCN indicated that all resident wounds were reviewed weekly by the IDT (interdisciplinary team) that would include the Dietitian. On 7/9/24 at 2:29 PM, an interview was conducted with the Dietitian Q regarding nutritional evaluation after Resident #46 developed the pressure injury. The Dietitian indicated the Resident had a good appetite and was taking protein Jello which the Resident had taken before but had been switched to a high protein snack due to diabetes, they went back to the protein Jello because of the wound and the prevalence of acceptance of the Jello by the Resident. When asked when she was contacted about Resident #46's facility acquired pressure injury, the Dietitian reported she did not have record of contact. When asked if she attended the IDT meetings where wounds were discussed, the Dietitian indicated she did attend. The Dietitian indicated she had seen the Resident closest to the development of the wound on 5/24/24 and stated, Typically I see them as soon as I know about it. When asked how staff contact the Dietitian, they reported by Teams, messaging, memo, and IDT. The WCN reported that the weekly IDT was a newer process they have been trying but did not indicate when the meetings had started. When asked if approximately a month after the development of the wound for a nutrition evaluation was appropriate, the Dietitian stated, Usually I would see them right away. On 7/10/24 at 9:51 AM, an observation was made of Resident #46 lying prone in bed. Wound Care Nurse P was observed doing a dressing change to Resident #46's injury to the heel area. The dressing was removed, area cleansed. The wound was pinkened and the WCN indicated it was healing well. The WCN applied the new dressing, followed hand hygiene, enhanced barrier precautions and insured comfort of the Resident. The Resident was asked to observe the other heel, consented, and the WCN removed the Resident's gripper sock with skin intact to heel area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility document titled Pressure Ulcer Protocol and Standing Orders, revealed, Return to ADON once initiated within in 72 hours. ***Complete with all new suspected pressure injuries*** . Intervention: . Nutrition Risk Assessment - 1 x(times)/(per)week . Notify Registered Dietitian . A review of facility policy titled, Pressure Injury Prevention and Management, revised/reviewed 2/14/24, revealed, Policy: The (Facility name) is omitted to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries . g. Nursing refers residents at risk for pressure injury development or residents with existing wounds to the Registered Dietician to review nutritional requirements for wound healing .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure that Resident #58 had oxygen available in the portable oxygen tank; properly store distilled water for a CPAP machine for a resident in room [ROOM NUMBER]-2; and remove/clean a CPAP machine for Resident #70, of four residents reviewed for respiratory care, resulting in the potential for infection, respiratory illness, low oxygenation, and shortness of breath. Findings include: Resident #58: A review of Resident #58's medical record revealed an admission into the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, heart disease, and anxiety disorder. A review of the Minimum Data Set (MDS) assessment revealed the Resident had moderately impaired cognition and needed moderate assistance with bathing, upper body dressing, and toileting. A review of Resident #58 revealed an order for oxygen, Apply oxygen (per nasal cannula) to maintain O2 sat > or equal to 90%, dated 1/22/23. The document received from the facility dated 6/10/24 to 7/9/24, revealed the Resident used 2 liters of Oxygen for 8 hours each 8-hour shift documented, average total of 24 hours a day. On 7/8/24 at 2:22 PM, an observation was made of Resident #58 in her wheelchair in her room and propelling herself around in the room. The Resident had oxygen nasal cannula tubing on that was connected to an oxygen tank that hung on the back of her wheelchair. The oxygen tank was on the red and indicated it was out of oxygen. The Resident was asked questions and could answer simple questions. The Resident was asked if she could feel if she was getting any oxygen flow through the nasal cannula. The Resident moved the nasal cannula around and indicated she did not think it was flowing. There was no sound noted when the resident adjusted the nasal cannula. The Resident was asked how long she had been out of oxygen but was unsure. CNA (certified nursing assistant) T was summoned to Resident #58's room to check the Resident's oxygen tank. The CNA indicated that the tank was on red and would get another tank. Nurse U was summoned to the Resident's room and was asked to monitor the Resident's oxygen saturation (O2 sat) that showed the O2 sat was 94% to 92%. The Resident was asked if she felt short of breath but denied shortness of breath. The CNA was asked about ensuring the Resident had enough oxygen in the tank and reported she recently started the shift and had not been in to check on the Resident. On 7/10/24 at 11:19 AM, an interview was conducted with Unit Manager, Nurse R regarding Resident #58 oxygen tank in the red and no flow of oxygen. When asked how often the Resident used the oxygen, the Nurse reported, she wears it all the time, when she was out of the room, she used the portable oxygen tanks and when in the room, she was put on wall oxygen. The Nurse reported that when the tanks were low or empty, the nurse will switch it out and reported that when it was getting low they should check it more frequently. Resident #70 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #70's medical record revealed an admission into the facility on [DATE] with diagnoses that included dementia, insomnia and sleep apnea. A review of the MDS revealed the Resident had severely impaired cognition. On 7/8/24 at 12:01 PM, an observation was made of Resident #70's room with a CPAP machine on the bedside table. There was a gallon jug of distilled water on the table that was opened, partially used and not dated with an open date. The CPAP machine had a chamber that was partially filled with water and the Resident had a nasal mask. The chamber had liquid in it and was not cleaned out and set to dry. On 7/10/24 at 9:49 AM, an interview was conducted with the Director of Nursing (DON) regarding the dating of the distilled water for CPAP/BiPAP machines when opened. When asked if the distilled water should be dated upon opening, the DON stated, Yes, I believe they should be dating those when they open them. On 7/10/24 at 10:27 AM, an interview was conducted with Unit Manager, Nurse R regarding storage and dating of distilled water used for CPAP or BiPAP machines. An observation was made of distilled water in room [ROOM NUMBER]-2, opened and partially used. When asked about dating the distilled water when opened, the Unit Manager stated, Yes they should be dating them. An observation was made of Resident room [ROOM NUMBER]-2, of the distilled water for the CPAP or BiPAP machine stored on the floor between a chair and the bedside table. The distilled water was opened, partially used and had a date of when it was opened. The Unit Manager indicated the distilled water was not to be stored on the floor and reported the Resident would put it on the floor herself. The water chamber on the machine had water inside. The Unit Manager was asked about letting the chamber dry and reported that Nursing staff were to empty them out daily and let them dry. A review of orders in the medical record, with the Unit Manager, revealed a lack of orders or documentation of drying the chamber daily. The policy for CPAP and BiPAP machines was requested. On 7/10/24 at 11:15 AM, an observation was made with Unit Manager, Nurse R of Resident #70 room. There was no CPAP machine on the bedside table and the equipment had been removed. When asked about the CPAP machine and if Resident #70 had a CPAP, the Unit Manager reported the Resident had been refusing the CPAP and it was discontinued. A review of Resident #70's medical record by the Unit Manager revealed the CPAP had been discontinued on 6/21/24. The observation of the CPAP machine with the water chamber partially filled and the distilled water not dated with an open date was reviewed with the Unit Manager. On 7/10/24 at 3:26 PM, an interview was conducted with the DON regarding storage of the CPAP machines. The DON reported the chamber is filled daily, my assumption is that it would be emptied daily and stated, If you clean the mask daily, then I would think you would clean the chamber as well. The DON reported that the facility policy did not indicate the distilled water needed to be dated. The DON indicated that the Resident in room [ROOM NUMBER]-2 had a stool where the distilled water was to be stored to keep it off the floor and the Resident had removed the water from the bedside table to the floor and that education was provided to the Resident. The CPAP/BiPAP policy had been requested but was not received by the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32000 Based on observation, interview, and record review the facility failed to maintain sanitary conditions in the kitchen resulting in an increased potential for cross contamination of food and foodborne illness, potentially affecting the facility's total census of 85 residents who receive meal services. Findings include: 1. On 7/8/24 at 11:02 AM, the floor in the walk in freezer was observed soiled and with visible debris on its surfaces. On 7/8/24 at 11:04 AM, a plastic container labeled as ground ham, and a bag of gluten free bread were observed on the floor underneath the wire rack shelving. Upon observation the surveyor inquired with Dietary Manager, staff A, on if they thought these areas were being cleaned timely and sufficiently to which they replied, yes, but our stock person comes in on Tuesdays and Fridays. They help with the cleaning and organizing. On 7/8/24 at 11:09 AM, broken eggshells and a container of heavy whipping cream were observed on the flooring in the walk in cooler. At this time the surveyor inquired with staff A on if they thought the flooring was being cleaned as needed throughout the day to which they replied, usually, it looks like they just mopped in here. I'm not sure why it is like this. On 7/8/24 at 11:12 AM, a heavy accumulation of ice buildup was observed on the exposed refrigerant lines in the walk-in cooler. At this time the surveyor inquired with staff A on if they were aware of the ice buildup in the refrigerator to which they replied, no, I can talk to maintenance about this. I would expect to see that in the freezer, but not here. On 7/8/24 at 11:15 AM, the surveyor requested a copy of the kitchen's cleaning policy to review. On 7/8/24 at 12:24 PM, during a dietary tour of the second floors kitchenette the surveyor observed a container of liquid butter stored in an upper cabinet with a heavy coating of liquid butter on the exterior of the container and on the base and the sides of the cabinet. At this time the surveyor inquired with staff A on if they were aware of the current state of the cabinetry to which they stated, no, I'm not sure why this in a container to brush it on, it's supposed to be in a squeeze bottle. On 7/9/24 at 8:47 AM, the floor in the walk in freezer was again observed soiled and with visible debris on its surfaces. On 7/9/24 at 10:18 AM, record review of a document titled, cleaning checklist kitchen week of 7/1 revealed a partially filled out cleaning schedule documenting the daily cleaning tasks required to be completed by staff. Upon review the surveyor inquired with staff A on the current state of the document to which they stated, it's a work in progress document. We are still trying to find the right fit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of 2017 U.S. Public Health Service Food Code, Chapter 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, directs that: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 2. On 7/8/24 at 12:14 PM, during a dietary tour of the third floors kitchenette the surveyor asked the Dietary Manager, staff A, how the facility cleans and sanitizes work surfaces in this area to which they stated, we have our red bucket that has our sanitizer. At this time the surveyor asked staff A if they could test a sanitizing bucket to verify its concentration to which they replied, yes. On 7/8/24 at 12:16 PM, testing of the sanitizer concentration by staff A via a test strip, and comparing its color to the test strip packaging revealed a concentration of zero. At this time a temperature taken by staff A of the chemical solution revealed a reading of 51 degrees F. Upon observation staff A stated, This might be from this morning, I'll call down to the kitchen and have them remake it now. On 7/9/24 at 9:34 AM, record review of the chemical container underneath the 3-compartment sink by the surveyor and staff A revealed the expectation to maintain the sanitizer at a concentration of 200ppm-400ppm and at a temperature of 75 degrees F. At this time the surveyor inquired with staff A on how the facility plan to achieve this result to which they stated, we change them out every four hours or as needed. Review of 2017 U.S. Public Health Service Food Code, Chapter 7-204.11 Sanitizers, Criteria, directs that: Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACEs shall: (A) Meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (Food-contact surface sanitizing solutions)P 3. On 7/8/24 at 12:38 PM, the surveyor observed a half gallon of milk resting in a half filled tray of ice cubes in the third floors dining room. At this time the surveyor asked staff A, if they could take a temperature of the remaining portion of milk from the days lunch service to which they stated, yes. On 7/8/24 at 12:41 PM, temperature verification from staff A's thermometer probe revealed a temperature of 53 degrees F. At this time the surveyor inquired with staff A on what they would normally do when identifying a potentially hazardous food product at a temperature such as this, they replied, throw it out. On 7/8/24 at 12:42 PM, upon observation the Regional Dietary Supervisor, staff B, stated, we can order some personal containers of milk to help them stay cold. Review of 2017 U.S. Public Health Service Food Code, Chapter 3-501.16, Time/Temperature Control for Safety Food, Hot and Cold Holding directs that: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) At 5 C (41 F) or less.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility failed to ensure 1) Resident and employee illness surveillance and monitoring, 2) Perform hand hygiene and don personal protection equipment (PPE) prior to entering a transmission-based precautions room, 3) Supply the staff with a trash receptacle for a transmission-based precautions room, and 4) Ensure that a urinary catheter bag was off the floor for one resident (Resident #20), resulting in the likelihood of contamination and spread of illnesses. Findings include. On 7/09/24, at 2:14 PM, an observation of CNA D who entered room [ROOM NUMBER] without performing hand hygiene, donned gloves but no gown or mask. The door to room [ROOM NUMBER] hand a contact isolation sign attached to an isolation caddy that housed gowns, masks and gloves. There was an additional sign posted on the door that stated contact and droplet isolation. CNA E walked to doorway and asked CNA D, do we need to and CNA D interrupted and stated, no, that's for bed 1 (Resident #42). CNA E entered the room without performing hand hygiene or donning PPE. Shortly after, CNA E exited the room and was asked if they needed to wear PPE prior to entering the room and CNA E stated, that's why I questioned it. On 7/09/24 2:20 PM, Surveyor entered room [ROOM NUMBER], CNA D was in the bathroom with only gloves on caring for the resident in bed 2. CNA D was asked if they planned to care for Resident #42 and CNA D stated, shortly. CNA E re-entered the room without performing hand hygiene nor donning PPE, placed a container of disinfectant wipes on top of the dresser and offered to CNA D be sure to wipe down the toilet. Upon exit of room [ROOM NUMBER], there was no trash can to discard the worn PPE and CNA D pulled the trash can from the bathroom and slid it near the doorway. On 7/09/24, at 2:45 PM, an observation of a staff member who entered room [ROOM NUMBER] to offer fresh fluids. The Staff member did not don any PPE prior to entering the room. On 7/10/24, at 1:09 PM, During infection control task along with the Director of Nursing (DON) and Infection Control (IC) Nurse C, a record review was conducted of the ongoing infection control line listing. There was no mapping noted of infections. IC Nurse C was asked for documentation for employee illnesses and who monitors that and IC Nurse C offered that there were yellow call-in slips that were housed in a box. A stack of yellow call-in slips was provided for review that were paper clipped together with the corresponding months attached for April, May and June. A review of the June call-in slips resulted examples of . fmla . personal . took family to doctor . vomiting . The DON offered that they get all the call-in slips and they go through them, post the call-in shift to get it covered. IC Nurse C was asked if they follow-up with the employees who call off for illnesses and IC Nurse C stated, they review them for trends. (continued on next page)

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	235028	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron CO Med Care Facility	1116 S Van Dyke Rd Bad Axe, MI 48413

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/10/24, at 2:23 PM, a review of the July, 24 resident infection line listing along with IC Nurse C was conducted in the DON's office. IC Nurse C was asked what type of transmission-based isolation Resident #42 required and IC Nurse C stated, contact isolation do to shingles. IC Nurse C was asked if the sign was on the door was the entire room on contact precautions and IC Nurse C stated, no just bed 1. IC Nurse C was asked if the bathroom inside room [ROOM NUMBER] was in contact precautions and IC Nurse C stated, no all bed 1 cares are at the bedside. IC Nurse C and the DON were both asked were they sure Resident #42 didn't use the bathroom and the DON clarified that yes, (Resident #42) does get up and use the bathroom. The DON offered that they use Direct contact precautions and are to only use PPE when changing linens or caring for the infected area. A record review of the contact isolation sign along with IC Nurse C revealed, CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person . On 7/10/24, at 2:43 PM, The DON and IC Nurse C were asked to clarify that the facility did or did not have an employee illness line list or tracking system and The DON offered that they did have employee illness line list during Covid and they do review the call-in slips. IC Nurse C and the DON were asked how they could ensure if vomiting was noted in employees and how they would related that to an outbreak in residents for example and the DON offered we review the resident's line list and if we noted two or more of the same illnesses for example e-coli we would go to the floor and do education. The DON offered that they do get emails from the scheduler for call-ins and does follow up although no documentation was provided. No documentation was offered in relation to employee illness tracking or an employee illness line list. On 7/10/24, at 3:26 PM, further interview with the IC Nurse C and the DON regarding the clarification of Direct contact precautions and that the CONTACT isolation sign hanging on door 320 did not explain Direct contact and how the staff dispose of PPE upon exit of an isolation room and the DON offered that they do educate on the need for PPE for Direct contact with the infection verbally and that there is a rolling cart near the doorway for disposal of linens and PPE/trash. The DON was alerted there was no cart for room [ROOM NUMBER]. The facility was asked to provide any further documentation of illness tracking and the most recent surveillance mapping for resident illnesses. A record review of the most recent mapping for resident illnesses was from September 2023 and the most recent employee illness tracking document was from November 2023 and was for Covid. 37666 Dining Observation On 7/08/24 at 12:00 PM in the 300 floor dining room, Certified Nursing Assistant K was observed helping a resident straighten her sock onto the residents foot, and pull it up. She did not perform hand hygiene after pulling up the resident's sock. Then the nursing assistant helped the resident with her cover up, and rearranged the items on the table, then left the tale and went to the hand sanitizer on the wall and performed hand hygiene. Resident #20 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #20 was initially admitted to the facility on [DATE] and readmitted from the hospital on 4/8/2024 with diagnoses: with acute respiratory failure, pneumonia, urinary tract infection, morbid obesity, chronic kidney disease, heart disease, chronic pain, depression, dementia, arthritis, urinary retention, urinary catheter, hepatitis C, neuropathy, and peripheral vascular disease. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 15/15 and needed assistance with all care. On 7/08/24 at 2:12 PM, during a tour of the facility, Resident #20 was observed lying in bed, reading a book. A urinary catheter bag was sitting on the floor; it was not hanging from the side of the bed. The hook to hang it was dangling in the air. On 7/09/24 10:03 AM, Resident #20 had a sign for Enhanced Barrier Precautions on the outside of his door with Personal Protective Equipment/PPE hanging on the door; the door was partially closed. Upon knocking, Certified Nursing Assistant/CNA J was observed making the resident's bed; he was not wearing PPE. He said the resident was across the hall in the shower. When asked if he was supposed to wear PPE, he said only if he touched the resident. He was asked if he should wear it to change the bed linens and he stated, No, they said only if we touched the resident or his wound. The CNA was asked if the resident also had a urinary catheter and he stated, Oh, yes he does have a Foley. Referenced the sign on the door with CNA J and it said to wear PPE when changing bed linens, CNA J stated, I will go put it on.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review the facility failed to follow standards of practice for laboratory testing and antibiotic use for one resident (Resident #25) of 4 residents reviewed for antibiotic use, resulting in Resident #25 receiving antibiotic treatment without appropriate laboratory tests to determine if the resident had a urinary tract infection and if the antibiotic was appropriate. Findings Include: Resident #25: Urinary Catheter or UTI A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #25 indicated admission to the facility on [DATE] with diagnoses: Alzheimer's dementia, diabetes, depression, peripheral vascular disease, heart disease, hypertension and a history of urinary tract infection/UTI. The MDS assessment dated [DATE] indicated the resident had severe cognitive loss and needed assistance with all care. On 7/08/24 at 11:31 AM, during a tour of the facility, Resident #25 was observed sitting in a chair in her room. She was confused and didn't answer questions. On 7/8/2024 at 12:25 PM, the Infection Prevention and Control/IPC Nurse C was interviewed about Resident #25. She said the resident had recently been treated with an antibiotic for a urinary tract infection. When asked if she had a copy of the laboratory reports: urinalysis and culture and sensitivity C&S) (used to identify a urinary tract infection and determine what the organism causing the infection was and what antibiotics were most effective to treat it), she said she would need to look it up. A review of the physician orders identified the following: Bactrim (antibiotic) 400 mg-80 mg tablet, 1 tablet twice a day for 10 days. On 7/8/2024 at 4:00 PM, the Director of Nursing provided a document titled, Risk Versus Benefit Dictation Needed, for Resident #25. It revealed the following: Type of Infection: UTI; Antibiotic initiated 400-80mg PO (by mouth) twice a day x 10 days; Date Antibiotic was initiated: 6/19/2024. Signs and Symptoms Present: Positive UA (urinalysis), increased yelling/behaviors. There was a section on the document for Diagnostics Ordered and Performed and it was blank; this included the headings for UA, Urine C&S and other. The form had a category for Rationale for Not Meeting Criteria for Infection and it revealed, No culture result/culture insufficient, no leukocytosis. There was no further explanation. The form was signed by the IPC Nurse C on 6/25/2024. The IPC Nurse had attached a sticky note to the form, but did not provide any laboratory results for the urinalysis or C&S. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 1:04 PM, Clinical Coordinator G was interviewed about Resident #25's antibiotic treatment. She provided copies of 3 urinalysis results for Resident #25: 6/19/2024, 6/22/2024 and 7/5/2024. The 6/19/2024 and 6/22/2024 urinalysis each showed positive epithelial cells of 5-10. The reference range identified none should be seen; this indicated potential contamination of the specimens. There were no C&S reports identifying an infectious organism or antibiotic sensitivity. Nurse G said she had contacted the Lab when they did not receive the C&S and she said the Lab told her they did not run the cultures. She said she was told after the 6/19/24 urinalysis to run another urinalysis but she did not know why. The 2nd urinalysis also showed 5-10 epithelial cells. She said Bactrim was ordered for the resident x 10 days without knowing if it would be effective. The last provider note was dated 6/2/2024 and did not include mention of signs and symptoms of a UTI for Resident #25. A review of a Bladder Management Care Plan for Resident #25 mentioned urinary tract infections but it had not been updated since 8/12/2022 and did not reference the resident's recent treatment with an antibiotic. A review of the facility policy titled, Antibiotic Stewardship Program, date implemented 3/10/2020 revealed, It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of this program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . the Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the Antibiotic Stewardship Program . Medical Director serves as the primary medical point of contact for the program and serves as a liaison between the facility and other medical staff members . Nursing staff shall assess residents who are suspected to have an infection . Laboratory testing shall be in accordance with current standards of practice .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 39059 Based on interview and record review, the facility failed to provide one resident (Resident #74) their 2023/2024 influenza vaccine, resulting in the likelihood of influenza contraction, hospitalization and/or death. Findings include: Resident #74: On 7/10/24, at 11:00 AM, a record review of Resident #74's immunizations revealed no influenza vaccine administration documentation. The facility was asked to provide proof of influenza vaccine documentation. A record review of Resident #74's Immunization Consent Form revealed Resident #74 gave permission for Influenza with their signature and a date of 5-13-24. On 7/10/24, at 2:27 PM, the DON offered that Resident #74 admitted with a gastrointestinal infection and was on antibiotics on and off. The DON offered that Resident #74 wasn't healthy enough to get the flu vaccine and then once they were it was passed the window to get the flu vaccine. On 7/10/24, at 3:35 PM, a record review along with the DON and the IC Nurse C of Resident 74's immunization list revealed that they received VACCINE ADMINSTERED . Sars-CoV-2 (Moderna Booster) Spikevax . Date Administered . 05/31/2024 . There was no documentation that Resident #74 received an influenza vaccine for the 2023/2024 flu season. The DON was asked if Resident #74 was healthy enough to get the COVID booster then why they weren't offered the flu vaccine and the DON again offered that they are not allowed to give flu vaccine after March 31st and the DON was asked to explain. The DON offered that the medical director doesn't allow flu vaccine administration after that. The DON was alerted that the flu vaccine doesn't expire until June 30th each year and flu still is contracted throughout spring, and what was the Medical Director's reasoning, and the DON was unsure. The DON was asked if they follow the CDC guidelines and the DON stated, yes. The DON was asked to provide documentation from CDC that states do not give flu vaccine after March 31st. The DON entered into CDC.gov and could not find any documentation that alerted long-term care facilities to not give flu vaccine after March 31st.