STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235039	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Grandville	3400 Wilson Ave Grandville, MI 49418

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to assist in finding an appropriate fitting wheelchair for one (R44) of one resident reviewed for wheelchair needs. Findings include: Resident #44 (R44) Review of a Face Sheet revealed R44 originally admitted to the facility on [DATE] and has pertinent diagnoses of lack of coordination, spinal stenosis in lumbar region with neurogenic claudication (nerve pain typically in both legs), morbid obesity, and limitation of activities due to disability and osteoporosis. Review of the Minimum Data Set (MDS) dated [DATE] for R44 revealed she was cognitively intact and utilizes a manual wheelchair. In an interview on 5/20/25 at 9:31 AM, R44 was in bed and reported the facility took her electric wheelchair away from her because they were concerned about her safety due to her high ammonia levels and some components of her electric wheelchair were broken so they were concerned about the steering mechanisms. R44 reported that she no longer has control over going outside and navigating the facility independently. R44 stated that she transitioned from having some independence to none at all. She now uses a manual wheelchair, which she finds difficult to self-propel. She pointed out areas of discoloration and bruising on her legs caused by bumps against the sharp edges of the wheelchair, which sometimes breaks the skin. Additionally, she complained that the wheelchair wobbles when she attempts to transfer into it. During an observation and an interview on 5/20/25 at 10:26 AM, R44 reported her feet could not reach the floor to self-propel in her wheelchair. At this time, she transferred from her bed to her wheelchair and once she sat down, her feet were in the air approximately 3 inches off the floor. R44 reported she will scoot to the middle of the seat so her toes can touch floor and move the wheelchair, but staff will tell her she needs to sit back in the wheelchair, so she does not fall. R44 reported sometimes she will push backwards in her wheelchair because it is easier, or she will use the rails on the side of the walls to help pull herself along. R44 complained her shoulder was sore from trying to pull herself along the wall the day before. R44 reported that losing her independence does not do well for her mind. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/21/25 at 11:14 AM, the Rehabilitation Director (RD) D reported R44 was deemed unsafe in her electric wheelchair before her admission to the hospital and agreed her current wheelchair does not fit R44 appropriately, but they do not make a wheelchair that sits low enough for her. In an interview on 5/21/25 at 11:23 AM, the Nursing Home Administrator (NHA) reported that R44 is not safe in an electric wheelchair and was told last year that the manual wheelchair R44 is in now meets her needs. At this time documentation was requested to show that R44 was properly fitted for her current wheelchair and any attempts made to find an appropriate fitting wheelchair. The NHA later reported that the current wheelchair R44 is 17-inch height and that is the lowest one they (the facility) have and could not find a lower sitting wheelchair. When questioned about how shorter people, including children, are accommodated for smaller wheelchairs and the fact that they exist, the NHA reported she would look into that. Later the NHA reported that the 17-inch wheelchair is the shortest one they make. No documentation provided by the end of this survey to show there is any correspondence or documentation to show there is no other wheelchair options for R44 that will fit her appropriately and safely. Review of Physical Therapy Treatment Encounter notes for R44 revealed the following: 3/18/25- WC (wheelchair) mobility performed in facility with bilateral UE's (upper extremities) long distances with intermittent cueing for safety negotiating obstacles. Pain: . Patient noting some bilateral knee soreness. 3/19/25- W/C mobility included turning around in narrow spaces, turning corners, passing through doorways, forward propelling and backward propelling. Pt (patient) prefers backward d/t (due to) short LE's (lower extremities) able to push self, otherwise using B UE (bilateral upper extremities) when going forward. Pain: . Pt stated having some pain in B knees d/t bone on bone and some pain in R (right) ankle). 4/9/25: Patient noting problem with wc catching during mobility. Noted screws on wheel rims loosened and hitting arm rest panel. Tightened screws and problem resolved. Patient also c/o (complains of) discomfort sitting in wc due to patient removing wc cushion secondary to being too high to reach floor with feet. Replaced wc cushion with lower profile cushion to trial. Patient able to perform WC mobility with lower extremities without assistance with some continued difficulty with foot contact on floor. Patient noted she would consider alternative footwear to improve contact and traction. In an interview on 5/22/25 at 8:56 AM, Physical Therapy Assistant (PTA) F reported he measured R44 this morning and her feet are 4 inches short from reaching the floor. R44 will push herself backwards which is not safe since she cannot see behind her. PTA F reported R44 will also pull herself down the hall using the wall rails. When questioned about the progress note on 4/9/25 regarding R44 considering alternative footwear to improve contact and traction, PTA F reported that would be helpful for anyone in general when self-propelling in a wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an ADL (Activities of Daily Living) Care Plan for R44 revealed: Focus: . I am able to meet my SAFEST and highest functional level of independence with use of my manual wheelchair. My guardian and physician have agreed that the electric wheelchair is a hazard to my safety and providing me with it as a tool I use to harm myself DOES NOT promote independence nor physical or mental wellness, last revised 4/24/25. Interventions included, but not limited to: I propel myself with a w/c (wheelchair). I have a seatbelt. I am able to unfasten my seatbelt independently. I often choose to remove seatbelt. I use a pommel style cushion provided by therapy, last revised 3/19/25. Review of a fall prevention Care Plan for R44 revealed: Intervention: . I have been evaluated by a physical therapist in the facility who states the manual w/c is able to meet my needs. I am able to utilize a manual wheelchair as designed with my upper body strength only. Despite being educated I choose to utilize my feet because it's easier. I do this knowing it increased my potential for falls. Initiated 10/28/24.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to notify the provider of abnormal vital signs for 1 of 6 residents (Resident #11) reviewed for notification of change. Findings: Resident #11 Review of an Admission Record revealed R11 was an [AGE] year-old female, admitted to the facility on [DATE]. Review of R11's Blood Pressure Summary revealed: *On 4/8/2025 9:00 PM R11's blood pressure was 209/92 no reassessment until 4/9/2025 at 9:27 AM. *On 5/12/2025 9:35 AM R11's blood pressure was 236/104 no reassessment until 8:40 PM. *On 5/20/2025 8:48 AM R11's blood pressure was 213/102 no reassessment until 7:12 PM. Review of R11's Provider Note dated 5/12/25 revealed, .Blood Pressure: 236/104 mmHg .BP recorded this morning quite high in the 200s systolic. Has previously been quite stable. Would like to recheck. If staying persistently elevated will adjust BP meds . Confirming the provider had not been notified of the elevated blood pressure but observed it in R11's Electronic Health Record. Review of R11's Electronic Health Record revealed no documentation that the providers were notified of the above elevated blood pressures. During an interview on 05/21/25 at 03:57 PM, LPN M reported that if a residents blood pressure was as high as R11's then a manual assessment should be completed. If the resident's blood pressure was out of range the provider would be notified. LPN M reported that any provider communication should be documented in the progress notes. During an interview on 5/22/25 at 10:33 AM, Nurse Practitioner (NP) N reported it was expected that the provider would be notified for blood pressures that were out of range and would have expected the licensed nurses to notify the provider of R11's blood pressures listed above and to reassess as well. During an interview on 05/22/25 at 11:14 AM, Nursing Home Administrator (NHA) and DON (Director of Nursing) reported that they had identified concerns with licensed nurses following notifying providers of abnormal vital signs. Nurse education and audits had been conducted beginning in February. On 05/22/25 at 11:50 AM any additional documentation regarding R11's elevated blood pressures and treatment/notification was requested. There was no additional documentation received prior to survey exit. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy dated 7/24 revealed, It is the policy of this facility to inform residents/legal representative, attending physician or designee of a change in the resident's condition . 2. The facility will inform the resident, consult with the resident's provider, and notify, consistent with his or her authority, the resident representative(s) when there is . b. A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c. A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for 4 residents (Residents #11, #50, #7, and #28) out of 18 residents and residents receiving controlled medications on the Garden Unit, reviewed for the provision of nursing services. Findings: On 05/20/25 at 09:43 AM, the Garden Unit Narcotic Book was reviewed. There were 9 residents that did not have their scheduled morning controlled medications (narcotics) documented as dispensed since 5/19/25. Review of the Garden Unit Medication Administration Record revealed there were no medications documented as not administered at the time of the Narcotic Book review. On 05/21/25 at 02:01 PM, the Garden Unit Narcotic Book was reviewed. The previous 9 residents' medications were documented as dispensed the morning of 05/20/25 with the times the medications were dispensed documented prior to 09:43 AM. Confirming the licensed nurse did not document the date and time at the time the controlled medications were dispensed. Resident #11 Review of an Admission Record revealed R11 was an [AGE] year-old female, admitted to the facility on [DATE]. Review of R11's Order Summary dated 4/25/25 revealed, CloNIDine HCl Tablet 0.1 MG Give 0.1 mg by mouth every shift for HTN (hypertension) ONLY GIVE MEDICATION IF SBP (systolic [top number] blood pressure) is GREATER than 160 or DBP (diastolic [bottom number] blood pressure) is GREATER than 90. HOLD MEDICATION IF OUTSIDE OF THESE PARAMETERS! To be administered on day shift if needed and night shift if needed. Review of R11's May Medication Administration Record revealed: *On 5/2/25 R11's blood pressure was 135/69 and the clonidine was administered on day shift. *On 5/2/25 R11's blood pressure was 128/61 and the clonidine was administered on night shift. *On 5/3/25 R11's blood pressure was 148/76 and the clonidine was administered on night shift. *On 5/4/25 R11's blood pressure was 142/77 and the clonidine was administered on day shift. *On 5/5/25 R11's blood pressure was 151/67 and the clonidine was administered on day shift. *On 5/6/25 R11's blood pressure was 160/68 and the clonidine was administered on night shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 5/7/25 R11's blood pressure was 133/71 and the clonidine was administered on night shift. *On 5/8/25 R11's blood pressure was 140/71 and the clonidine was administered on day shift. *On 5/8/25 R11's blood pressure was 159/83 and the clonidine was administered on day shift. *On 5/9/25 R11's blood pressure was 159/83 and the clonidine was administered on night shift. Resident #50 (R50) Review of an Admission Record revealed R50 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R50's Order Summary dated 4/27/25 revealed, Lisinopril Oral Tablet 5 MG (Lisinopril) Give 1 tablet by mouth one time a day for htn HOLD if SBP < (less than) 100, Pulse < (less than) 60. Review of R50's Blood Pressure Summary and Pulse Summary revealed there were no blood pressure or heart rate assessments documented on 5/2/25, 5/7/25, 5/9/25, 5/13/25, or 5/19/25. Review of R50's May Medication Administration Record revealed: *On 5/2/25 R50's lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/7/25 R50's lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/9/25 R50's lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/13/25 R50's lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/19/25 R50's lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. Resident #7 (R7) Review of an Admission Record revealed R7 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R7's Order Summary dated 4/29/25 revealed, Lisinopril Oral Tablet 10 MG (Lisinopril) Give 1 tablet by mouth two times a day for HTN Hold if Systolic < 90. Notify physician if SBP is greater than 165 or DBP is greater than 95. Review of R7's Blood Pressure Summary and Pulse Summary revealed there were no morning blood pressure or heart rate assessments documented on 5/2/25, 5/7/25, 5/9/25, 5/13/25, or 5/19/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R7's May Medication Administration Record revealed: *On 5/2/25 R7's morning lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/7/25 R7's morning lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/9/25 R7's morning lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/13/25 R7's morning lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. *On 5/19/25 R7's morning lisinopril was administered. The blood pressure and heart rate from the previous shift was documented. During an interview on 05/21/25 at 03:57 PM, Licensed Practical Nurse (LPN) M reported that some resident medications have parameters ordered and those parameters are expected to be followed. During an interview on 5/22/25 at 10:33 AM, Nurse Practitioner (NP) N reported it was expected that medications were administered following the provider order which including obtaining and assessing vital signs prior to the administration of medications. During an interview on 05/22/25 at 11:14 AM, Nursing Home Administrator (NHA) and DON (Director of Nursing) reported that they had identified concerns with licensed nurses following ordered parameters. Nurse education and audits were conducted beginning in February to ensure medications were administered within the ordered parameters. NHA reported they had not identified concerns with nursing staff utilizing previous shift vital signs (blood pressures and heart rates) when administering medications and the expectation was for vitals to be assessed immediately prior to the administration of medications. During an interview on 05/22/25 at 12:16 PM, DON and NHA confirmed that R7 and R50 had not had vital signs assessed prior to the lisinopril administration on the dates listed above. NHA reported they identified that it had been 1 nurse that administered the medications, and she was immediately educated. Review of the licensed nurse's education revealed, .It can be observed in the MAR (medication administration record) for more than one resident this nurse copying vitals last collected prior to administering medications, this creates potential for safety risk to resident as vitals should be obtained within window of med pass so parameters can be followed. Review of the facility policy Controlled Substances last revised January 2018 revealed, .D. Accurate accountability of the inventory of all controlled substances is maintained at all times. When a controlled substance is administered, the nurse administering the medication immediately enters the following information on the controlled substance count sheet and on the Medication Administration Record (MAR): (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Date and time of administration (MAR, controlled substance count sheet) 2) Amount administered (controlled substance count sheet) 3) Remaining quantity (controlled substance count sheet) 4) Initials of the nurse administering the dose (MAR, controlled substance count sheet) . Review of the facility policy Medication Administration-General Guidelines last revised June 2019 revealed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.2) Medications are administered in accordance with written orders of the prescriber . Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (Nurses) are also responsible for documenting any preassessment data required with certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 643-644). Elsevier Health Sciences. Kindle Edition. 29073 Resident #28 (R28) Review of an Admission Record reflected R28 admitted to the facility on [DATE] with diagnoses that included congestive heart failure, atherosclerotic heart disease, atrial fibrillation, hypertensive heart disease with heart failure, ischemic cardiomyopathy and a history of other venous thrombosis and embolism. Review of a Follow-up visit note, documented by Nurse Practitioner (NP) N on 4/29/2025, indicated R28's PT/INR was 3.6/43.7 (Prothrombin Time/International Normalization Ratio, a blood test that measures how quickly blood clots). Will hold coumadin (a blood thinning medication) x one dose and repeat PT/INR on Friday. Review of a Follow-up visit note, documented by Nurse Practitioner (NP) N on 4/30/2025 reflected R28's coumadin was not held as intended and his PT/INR was 5.0/60.00. Will hold coumadin x 2 days, then re-check pt/inr on Friday. He denies any unusual bruising or bleeding. He has 2+ non-pitting edema to LLE (left lower extremity, 1+ non pitting edema to RLE (right lower extremity. He is resting with eyes closed but awakens to verbal stimuli. He denies any new or uncontrolled pain. He reports stable mood, sleep, appetite patterns. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nursing Incident Note dated 5/1/2025 reflected the medication error and indicated order was not held or discontinued, and warfarin was administered. Immediate intervention implemented: educated staff r/t (related to discontinuing and putting orders on hold in (electronic medical record). Review of Coagucheck: PT/INR Test Log for R28 reflected 11 entries from dates 4/3/2025-5/21/2025. An entry on 4/29/2025 at 0630 (6:30 AM) indicated R28's PT/INR was 3.6/43.7 without a Current Coumadin Dose recorded. The next entry recorded on the log was dated 5/6/2025. The PT/INR of 5.0/60.00 was not entered onto the log. No diagnosis was included on the log indicating the reason R28 required the anticoagulant and an INR Goal Range was also NOT specified. Review of a Physician Progress Note dated 5/3/2025 reflected the Physician, DO P saw R28 for a Regulatory Visit and noted This [AGE] year-old male was seen for a regulatory visit. He transferred to (name of facility) on 7/29/24 after a hospitalization for UTI/septic shock. He uses a wheelchair now and can propel it himself according to a PT (physical therapy) note. He has memory loss. He has a history of DVT/embolism. His LLE is more swollen than his RLE. A recent ultrasound showed peroneal DVT which is chronic. He is on coumadin. His LLE is not tender when I palpate it. His INR is in the appropriate range. Further review of the clinical record did not reflect evidence that a PT/INR had been obtained prior to the next recorded value on the PT/INR log. The progress note was not electronically signed by the DO P until 5/7/2025, making it unclear if DO P saw R28 on 5/3/2025. During an interview on 5/21/2025 at 3:03 PM, Licensed Practical Nurse (LPN) L reported that she was a brand new nurse and just off orientation at the facility. When asked about the facility procedures for PT/INR monitoring, reporting and documentation, LPN L said she had no idea and would have to ask someone to help her learn the process. During an interview on 5/21/2025 at 3:04 PM, LPN G reported that she had no idea what the PT/INR protocols at the facility are and that it differs on each unit. LPN G said there are logs in the med books and in progress notes. During an interview on 5/21/2025 at 3:09 PM, LPN H reported that PT/INR is obtained with a machine in the facility via test strips. The results are recorded on a log maintained in the narcotic book on the med cart and noted in the computer charting, the physician/provider is notified, and orders are updated. Side effect monitoring is completed daily for any resident who is on an anticoagulant. During an interview on 5/22/2025 at 10:31 AM, NP N reported that she was educated about how to enter orders into the electronic medical record to prevent medication errors in the future. NP N reported the therapeutic range for R28's PT/INR was 2.5-3.5. NP N reviewed the progress note written by DO P and stated that based on the information available in the clinical record and the PT/INR Test Log, the PT/INR for R28 at that time was not in the therapeutic range for DVT or atrial fibrillation. An attempt to contact DO P via telephone was made on 5/22/2025 at 12:07 PM. A voice message was left requesting a return call. During a telephone interview with DO P on 5/23/2025 at 4:17 PM, DO P was not able to locate the PT/INR value used to determine that as of 5/3/2025 R28's INR was in the appropriate range. According to DO P, he wasn't sure where nursing staff recorded the PT/INR readings measured at the facility. DO P said the therapeutic PT/INR goal for R28 was 2.0-3.0, unless he had a heart valve issue. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The health care record provides a way for members of the interprofessional health care team to communicate about multiple aspects of patient care, including patient needs and response to care and therapies; clinical decision making; and the content and outcomes of consultations, patient education, and discharge planning. Information communicated in the health care record allows health care providers to know a patient thoroughly, facilitating safe, effective, timely, and patient-centered clinical decision making. The health care record is the most current and accurate, continuous source of information about a patient's health care status, allowing the plan of care to be clear to anyone who accesses the record. To enhance communication and promote safe patient care, you document assessment findings and patient information as soon as possible after you provide care (e.g., immediately after providing a nursing intervention or completing a patient assessment). The quality of patient care depends on your ability to communicate with other members of the health care team (see Chapter 24). When a plan is not communicated to all members of the health care team, care becomes fragmented, tasks are repeated, and delays or omissions in care often occur. The health record is an important means of communication because it is a confidential, permanent, legal documentation of information relevant to a patient's health care. The record is an ongoing current and accurate account of a patient's health care status and is available to all members of the health care team. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 366). Elsevier Health Sciences. Kindle Edition. Legal Guidelines for Documentation . Errors in recording can lead to errors in treatment or may imply an attempt to mislead or hide evidence . Record must be accurate, factual, and objective. Be certain that each entry is thorough. A person reading your documentation needs to be able to determine that a patient received adequate care. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 366). Elsevier Health Sciences. Kindle Edition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview, and record review, the facility failed to assess and address edema, significant weight gain, and follow through with physician orders for one (R44) who was reviewed for quality of care. Findings include: Resident #44 (R44) Review of a Face Sheet revealed R44 originally admitted to the facility on [DATE] and has pertinent diagnoses of stage III chronic kidney disease, diabetes, morbid obesity, and cardiac murmur. Review of the Minimum Data Set (MDS) dated [DATE] for R44 revealed she was cognitively intact. During an observation and an interview on 5/20/25 at 9:31 AM, R44 was laying down in bed with her legs horizontal. She reported that she had to go to the hospital a couple months ago because she had high ammonia levels, which resulted in her experiencing some psychiatric issues. R44 was unhappy because she felt the facility could have caught it earlier. R44 reported having a fall when her ammonia levels were high and was accused of throwing herself on the floor. R44 stated Who does that? R44 reported the facility was to recheck her ammonia levels since she came back from the hospital a couple months ago and they still have not done it. Review of the Electronic Medical Record (EMR) for R44 revealed no laboratory results or hospital records indicating abnormal ammonia level concerns or any labs with resulting ammonia levels. Review of an Order Summary for R44 revealed on 4/24/25 there was an order for Lab: Ammonia one time only for psychotic features/confusion for 1 Day. During an observation and an interview on 5/20/25 at 10:26 AM, R44 was still lying in bed with her legs horizontal and uncovered. R44 was able to reach her shin to push in on her skin when a 2+ pitting edema was noticed. Review of R44's weight history in the electronic medical records (EMR) revealed some of the following weights: 3/14/25- 231.7 Lbs (pounds) Floor Scale 4/10/25- 248.2 Lbs Wheelchair (A 16.5-pound weight gain since 3/14/25) 4/11/25- 248 Lbs Floor Scale 4/22/25- 237 Lbs Floor Scale (An 11-pound weight loss from 4/11/25) 4/23/25-244.3 Lbs Floor Scale (A 7.3-pound weight gain from the day before) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/4/25- 246.6 Lbs Floor Scale 5/8/25- 254 Lbs Wheelchair 5/9/25- 254.3 Lbs Wheelchair (A 22.6-pound weight gain since 3/14/25) In an interview on 5/22/25 at 9:41 AM, Registered Nurse (RN) E reported she would assess residents if they prompted for skilled charting. RN E was not aware of R44's weight gain or her edema. RN E went to R44's room at this time to do an assessment and reported R44 did have 1-2 + pitting edema in her bilateral lower extremities and her hands were swollen and rings on her fingers were tight and indented. RN E' reported R44 does like to eat a lot of unhealthy foods and lots of soda. RN E did confirm R44 was not on any diuretics now and will reweigh R44 to make sure they have an accurate weight. RN E reported that a weight fluctuation like this would usually trigger dietary as well to question the change. In an interview on 5/22/25 at 9:57 AM, Unit Manager (UM)/Licensed Practical Nurse (LPN) B reported she would expect staff to recheck the weight for R44. UM B did not know of any ammonia labs ordered for R44. In an interview on 5/22/25 at 12:24 PM, the Director of Nursing (DON) reported if a resident has a big fluctuation in weights like R44, she expects staff to reweigh residents for accuracy, then notify the provider and educate the resident on food and fluid intake and confirmed that it was not done. When queried about the ammonia lab orders for R44, the DON could not find that it was completed and later reported it was never done. The DON reported the physician put the orders in the EMR but it did not prompt the nursing staff to make sure it was done. Review of Care Plan interventions for R44 revealed the following: -Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Initiated 9/16/24. -Draw labs as needed to monitor for electrolytes imbalances when needed. Initiated 11/5/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 37573 Based on observation, interview, and record review, the facility failed to implement preventative care and services of pressure injuries for one (R15) of two residents reviewed for pressure injuries. Findings include: Review of a Face Sheet for R15 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of Parkinsonism, scoliosis (irregular curvature of the spine), and spondylosis with myelopathy in the cervical region (neurological deficit related to the spinal cord). Review of the Minimum Data Set (MDS) dated [DATE] for R15 revealed she is severely cognitively impaired and has bilateral limited range of motion on her upper and lower extremities and requires substantial/maximal assistance for bed mobility. R15 is documented as not being a high risk for pressure ulcers which conflict with the Braden Scale Assessment done on 3/1/25. During an observation on 5/20/25 at 9:48 AM, R15 is in bed lying on her back, eyes closed, neck resting on a neck pillow, and bilateral legs resting on two pillows and the left foot appears to be contracted in a forward position (plantar flexion). Review of a Braden Scale for Determining Pressure Ulcer Risk for R15 dated 3/1/25 revealed she is at high risk for developing pressure ulcers. During an observation and an interview on 5/20/25 at 11:08 AM, R15 was observed in bed on her back with her neck resting on a neck pillow and her legs resting on 2 pillows with her heels over them. R15 reported she used to have a pressure ulcer on her back but not anymore. R15 reported staff are to reposition her often but she must put the call light on for them to come to her room to do anything. R15 reported she is uncomfortable. During an observation on 5/20/25 at 2:06 PM, R44 was still in bed lying on her back in the same position as the last observation with her legs elevated on pillows. During an observation and an interview on 5/20/25 at 3:40 PM, R15 was in bed in the same position as the previous observation. Certified Nursing Assistant (CNA) J went into R15's room for incontinence care. R15 had a large tennis ball sized reddened/purple area on her coccyx that was blanchable and rated pain in that area at a 7 out of a 10-point scale. When asked if R15 hurts when she changes positions, R15 reported it hurt more to just lay there in that same position. At this time CNA J place a pillow on her left side to offload her weight. During an observation on 5/21/25 at 8:50 AM and 10:54 AM, R15 was observed on her back with her neck resting in a neck pillow and her legs elevated on two pillows. During an observation on 5/21/25 at 12:30 PM, R15 just received her lunch tray and was sitting up more in her bed at a 45 degree angle eating her meal. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and an interview on 5/21/25 at 1:47 PM, R15 was lying in bed on her back with her legs elevated on 2 pillows. R15 reported she had pain on her backside/buttocks and knees and rated the pain at 7/10 scale. During an observation and interview on 5/21/25 at 2:25 PM, CNA K reported she did not recall seeing any redness or discoloration on R15 when she provided incontinence care earlier. When asked why R15 was not repositioned all day, CNA K reported there were no orders for R15 to be repositioned. During an observation and an interview on 5/21/25 PM at 4:04 PM, Licensed Practical Nurse (LPN) L assisted R15 with incontinence care and observed a large reddened/purple area on her coccyx that was blanchable. R15 reported she was uncomfortable. In an interview on 5/22/25 at 10:26 AM, Unit Manager (UM)/LPN B reported R15 has a history of refusing care. Staff should attempt to reposition R15 and inform the nurse if she refuses to be repositioned. Staff should also reapproach the resident if she refuses. In an interview on 5/22/25 at 12:38 PM, the Director of Nursing (DON) stated she expects all CNAs to reposition residents who are in bed all day, every 2 hours. Review of the Care Plan revealed: I am at risk for impaired skin integrity r/t weakness/debility, COPD, polyneuropathy, incontinence, Vit B12 deficiency, scoliosis, hypothyroidism, chronic pain syndrome. I often refuse to get out of bed, sit in w/c, and be turned. (last revised 5/13/25) Interventions included: - Assess and monitor me for pain Initiate my preferred non-pharmacological interventions prior to initiating medication, as applicable. Follow-up as indicated. -If I decline treatment, confer with me, IDT and my representative, as applicable, to determine why and try alternative methods to gain compliance. -Pressure reduction support surface in bed, type: APM, date applied: 3/21/25 No high risk for pressure ulcers is focused on the care plan with meaningful interventions to drive a personalized plan of care for R15. Review of a policy titled Skin and Pressure Injury Risk Assessment and Prevention last revised 2/24 revealed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). c. Evidence-based interventions for prevention will be implemented for residents who are assessed at risk and/or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Maintain or improve nutrition and hydration status, where feasible.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview, and record review, the facility failed to identify and implement measures to prevent foot drop for one (R15) of one resident reviewed for positioning. Findings include: Review of a Face Sheet for R15 revealed she originally admitted to the facility on [DATE] and has pertinent diagnoses of Parkinsonism, scoliosis (irregular curvature of the spine), and spondylosis with myelopathy in the cervical region (neurological deficit related to the spinal cord). Review of the Minimum Data Set (MDS) dated [DATE] revealed she is severely cognitively impaired and has bilateral limited range of motion on her upper and lower extremities and requires substantial/maximal assistance for bed mobility. Review of the Electronic Medical Records for R15 revealed she had no diagnosis of contractures or foot drop. During an observation on 5/20/25 at 9:48 AM, R15 is in bed lying on her back, eyes closed, neck resting on a neck pillow, and bilateral legs resting on two pillows and the left foot appears to be contracted in a forward position (plantar flexion/foot drop). During an observation and an interview on 5/20/25 at 11:08 AM, R15 was observed in bed on her back with her neck resting on a neck pillow and her legs resting on 2 pillows with her heels over them. Her left foot is resting over the pillows in a plantar flexion position. During an observation on 5/20/25 at 2:06 PM, R44 was still in bed lying on her back in the same position as the last observation with her legs elevated on pillows and her left foot is still in a plantar flexion position. During an observation and an interview on 5/20/25 at 3:40 PM, R15 was in bed in the same position as the previous observation. During an observation on 5/21/25 at 8:50 AM and 10:54 AM, R15 was observed on her back with her neck resting in a neck pillow and her legs elevated on two pillows and her left foot in a plantar flexion position. During an observation and an interview on 5/21/25 at 1:47 PM, R15 was lying in bed on her back with her legs elevated on two pillows with her left foot in a plantar flexion position. During an observation and interview on 5/21/25 at 2:25 PM, CNA K was asked why R15 was not repositioned all day, CNA K reported there were no orders for R15 to be repositioned. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and an interview on 5/21/25 PM at 4:04 PM, Licensed Practical Nurse (LPN) L assisted R15 with incontinence care and observed a large reddened/purple area on her coccyx that was blanchable. R15 reported she was uncomfortable. In an interview on 5/22/25 at 10:26 AM, Unit Manager (UM)/LPN B reported she was not aware of R15 having any contractures in her left foot and not sure if she would benefit from any active or passive range of motion (ROM) care. If R15 would benefit from any ROM care, it would be ordered by hospice or therapy. In an interview on 5/22/25 at 12:38 PM, the Director of Nursing reported that R15 had foot drop in her left leg and that hospice confirmed it and documented it this day. Review of a Hospice Nursing progress note dated 5/22/25 for R15 revealed: While at facility was requested to assess foot drop which is present to left foot. Review of the Care Plan for R15 revealed no focus for positioning for limited ROM on the bilateral upper and lower extremities.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment, and ensure proper cooling of food affecting 75 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. On 05/22/25 between 9:10 AM and 10:05 AM during the initial tour with Certified Dietary Manager (CDM) A the following concerns were observed: Observation of the cookline revealed the Accutemp Steamer had one end of a drain line directly connected to the bottom of the steamer. The other end of the drain line went down through the grated floor drain and was submerged directly into the sewer drainpipe. Review of the FDA 2017 Food Code Section, 5-402.11 Backflow Prevention. Reflects the following, .a direct connection may not exist between SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. Further observation of the cookline revealed a build-up of grease, grime and food debris behind/under the cooking equipment. Review of the FDA 2017 Food Code Section, 6-501.12 Cleaning, Frequency and Restrictions. Reflects the following, (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. Observation of the Kelvinator 3 door line cooler was observed to be empty and had orange sticky not posted on a door of the cooler that stated, breakers Not working everything moved to [NAME] The unit is needed for cold holding food storage and ensuring safe food service operations. Review of the FDA 2017 Food Code Section, 4-501.11 Good Repair and Proper Adjustment. Reflects the following, (A) Equipment shall be maintained in a state of repair and condition that meets the requirements under 4-1 and 4-2. Review of the FDA 2017 Food Code Section, 4-301.11 Cooling, Heating, and Holding Capacities. Reflects the following, EQUIPMENT for cooling and heating FOOD, and holding cold and hot FOOD, shall be sufficient in number and capacity to provide FOOD temperatures as specified under Chapter 3. Observation of the can opener blade reflected stuck on food residue and debris. Observation of the clean pan storage shelving on the cook line revealed a few pans were soiled with stuck on food residues and debris. Review of the FDA 2017 Food Code Section, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces and Utensils. Reflects the following, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean sight to touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. Observation of [NAME] 3-Door-Cooler revealed a burnt-out light bulb. (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 the FDA 2017 Food Code Section, 6-303.11 Intensity. Reflects the following, The light intensity shall be: .(B) At least 215 lux (20-foot candles): . (2) Inside EQUIPMENT such as a reach-in and under-counter refrigerators; . Observation of the ice machine revealed no date mark on the filter. During the interview the CDM A stated she was unsure when it was last replaced. Review of the FDA 2017 Food Code Section, 5-205.13 Scheduling Inspection and Service for a Water System Device. A device such as a water treatment device or backflow preventer shall be scheduled for inspection and service, in accordance with manufacturer's instructions and as necessary to prevent device failure based on local water conditions, and records demonstrating inspection and service shall be maintained by the PERSON IN CHARGE. Observation of the Walk In Freezer and Walk In Cooler revealed food residue and debris on flooring. Further observation of the Walk in Cooler revealed containers of Sloppy [NAME] & Ravioli both had a date mark of 5/19/25. Condensation droplets were observed on the underside of both lids indicating a possible cooling concern. Review of the FDA 2017 Food Code Section, 6-501.12 Cleaning, Frequency and Restrictions. Reflects the following, (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. Review of the FDA 2017 Food Code Section, 3-501.14 Cooling. Reflects the following, (A) Cooked POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR FOOD SAFETY) shall be cooled: (1) Within 2 hours from 57 degrees Celsius (135 degrees Fahrenheit) to 21 degrees Celsius (70 degrees Fahrenheit), and (2) Within a total of 6 hours from 57 degrees Celsius (135 degrees Fahrenheit) to 5 degrees Celsius (41 degrees Fahrenheit) or less. During observation of Walk In Cooler CDM A was asked how they were cooling and if they had a cooling log. CDM A revealed their cooling logs were marked/monitored on their daily temp log sheets. Review of the 5/19/25 temp log reflected that staff had failed to document cooling for both the Sloppy Joes & the Ravioli. An obaervation 05/20/25 11:26 AM, of the locked Nutritional Refigerator (located in dining room on 300 hall) revealed soiled/sticky shelving. Review of the FDA 2017 Food Code Section, 4-602.13 Nonfood- Contact Surfaces. Reflects the following, NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumualtion of soil residues. During and interview on 5/20/25 at 11:52 AM, CDM stated she had an in-service on cooling policy and procedures with two of my cooks. CDM A revealed her last cook is off and will be educated when they get back. During the kitchen observation on 5/20/25 at 11:53 AM, NHA revealed a new ice machine filter had been ordered and would be here tomorrow.

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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** 29073 Based on observation, interview and record review, the facility failed to implement its infection prevention and control policies and procedures for glucometer cleaning, equipment cleaning and Management of C. Difficile Infection for two residents (R16 & R39) out of a total sample of 18 residents reviewed. Findings: Resident #39 (R39) Review of an Admission Record reflected R39 admitted to the facility on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the digestive system, contact with and (suspected) exposure to other viral communicable diseases, ventral hernia without obstruction or gangrene, disruption or dehiscence of closure of internal operation (surgical) wound of abdominal wall muscle or fascia, sequela and enterocolitis due to clostridium difficile (c. diff), not specified as recurrent. Review of a Nursing Progress Note dated 5/9/2025 reflects C. Diff test positive, contact precautions in place from time suspected and on-going, call placed to on-call NP (nurse practitioner) regarding, she states she will review lab and enter an order, Pt. (patient) notified of results, also (name of hospice provider) notified. Review of a Care Plan initiated on 5/9/2025 reflected I (R39) have an active infection: C-diff; Interventions on the care plan specified Administer anti-viral as per MD orders (clostridium difficile is a bacterium, not a virus and can cause severe diarrhea and colitis, which are inflammation of the colon.) The care plan also specified R39 was to be on CONTACT precautions. No further interventions were noted on the care plan. Review of a Kardex (a quick reference guide used by nurse aides to provide instruction for care) printed on 5/22/2025 reflected R39 required CONTACT precautions when providing care. No further information pertaining to c. diff was provided. Resident #16 (R16) Review of an Admission Record reflected R16 was admitted to the facility on [DATE] with diagnoses that included bipolar II disorder, vascular dementia, & muscle weakness. Review of a Care Plan initiated on 3/14/2022 indicated R16 had generalized weakness and required Supervision assist with 4WW (Four wheeled walker) and Personal Hygiene: Supervision. Further review of the entire care plan also reflected that R16 sometimes wander in the hallways or into other residents room . Further review of the entire care plan and Kardex did not reveal any indication R16 was sharing a room with a resident who was infected with C. diff. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/22/2025 at 9:02 AM, Registered Nurse (RN) B indicated she was the Infection Control Nurse (IC) Nurse at the facility. RN B said that R39 was placed in contact precautions as soon as it was suspected that she may have C. diff. RN B indicated that staff were instructed to don personal protective equipment (PPE) when entering R39's room and all trash and/or linens were to be removed from the room in red bio-hazard bags and that staff were to wash their hand with soap and water because alcohol-based hand rub was ineffective against the C. diff spores. RN B reported that R39 did not use the shared bathroom, and a private room was not available, so staff were instructed to treat both residents in the room as if they were both in contact precautions. RN B reported that R16 (R39's roommate) was able to transfer independently and used a 4WW with supervision. RN B said that no interventions such as assisting/ensuring R16 wash their hands with soap and water prior to leaving the room or cleaning the walker had been added to factor in R16's likelihood of touching contaminated surfaces and leaving the room to ambulate around the facility. During an observation on 5/22/2025 at 12:17 PM, RN B donned PPE and entered R39's room as Certified Nurse Aide (CNA) C was exiting R39's room with two clear plastic bags of soiled materials. CNA C was not observed washing her hands with soap and water. A red biohazard bin was a few feet away from the head of the bed against a partially drawn privacy curtain separating R39's side of the room from R16's side of the room. A clear plastic trash bag was inside the red biohazard bin. R39 reported the bin had just been placed in her room. During an interview on 5/22/2025 at 12:33 PM, CNA C reported she had just been educated by RN B who had observed her leaving R39's room without washing her hands with soap and water after providing care to R39. CNA C reported she did not know hand sanitizer was ineffective against C. diff. Review of a policy Management of C. Difficile Infection last revised 1/24 reflected This facility implements facility-wide strategies for the prevention and spread of Clostridioides difficile (C. difficile) infections. Clostridioides difficile, formerly known as Clostridium difficile and often-called C. diff, is a bacterium that causes diarrhea and colitis (an inflammation of the colon). It is shed in feces and is spread by direct contact with contaminated objects or the hands of persons who have touched a contaminated object. 2. Potential complications and risks associated with C. difficile include: a. hospitalization b. Pseudomembranous colitis c. Toxic megacolon d. Sepsis e. Death . General principles related to contact precautions for C. difficile: All staff are to wear gloves and a gown while providing care for the resident with C. difficile infection or having direct contact with items in their environment. Hand hygiene shall be performed by handwashing with soap and water in accordance with facility policy for hand hygiene. Maintain contact precautions for the duration of illness per CDC Isolation Precautions Appendix A. Encourage/assist residents to wash hands frequently. Use disposable equipment whenever possible. Thoroughly clean and disinfect reusable equipment with a sporicidal disinfectant that is compatible with the equipment. Disinfected items with fecal soiling (i.e. bedpans, commode chairs, bedrails, etc.). A private room with a dedicated toilet is preferred. If a private room is not available: i. Prioritize residents with bowel incontinence for placement in private room. ii. If cohorting (i.e. room sharing) is required, cohort residents with the same organism, with a dedicated toilet. Treatment for C. difficile infection will be in accordance with physician orders, current treatment guidelines, and local sensitivity/susceptibility data. Environmental infection control: Housekeeping staff shall adhere to standard and contact precautions. Perform daily cleaning of the resident's room and high touch surfaces using a C. difficile sporicidal agent (EPA List K agent). Perform terminal cleaning after the resident is transferred/discharged with a C. difficile sporicidal agent (EPA List K agent). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235039	A. Building B. Wing	05/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	37872 During an interview on 05/22/25 at 11:40 AM, Laundry Aide (LA) O revealed she has never been educated on the procedure for handling clothing/linens contaminated with C-Diff. LA O further revealed, I sometimes will separate residents' load (in the red bio-hazardous bags) because I do not want to wreck their personal clothing in bleach, but I will wash all the other items in a bleach load. LA O further revealed R39's laundry, usually comes down in regular (clear) bags. During an interview on 5/22/25 at 11:55 AM, Registered Nurse (RN) B revealed R39's soiled lines are supposed to be placed in the red (biohazardous) bags and/or bags that dissolve in the wash. Aides grab the new bags from the PPE bins (located outside of residents' room) when going in to provide care. RN B further revealed laundry is supposed to wash them separately. During an observation on 5/22/25 at approximately 12:06 PM, Certified Nurse's Aide (CNA) Q and Certified Nurse's Aide (CNA) C were observed gowning up to enter R39's room. (No red or dissolvable bags observed in Personal Protection Equipment (PPE) bins located outside room.) CNA Q further revealed they did not have any red bags located in the residents' room and would have housekeeping get more. 37573 Glucometer and Blood Pressure Cuff Cleaning During an observation on 5/21/25 at 8:12 AM, Licensed Practical Nurse (LPN) G went to room [ROOM NUMBER]-1 to check a blood pressure with a blood pressure cuff and check a blood sugar level with a glucometer for that resident. When LPN G was done, she left the room without cleaning the equipment and sat the devices on top of the medication cart. At 8:56 AM, LPN G went to room [ROOM NUMBER]-1 to check a resident's blood sugar with the same uncleaned blood pressure cuff and glucometer. After leaving room [ROOM NUMBER]-1, LPN G took the devices out of the room and sat them on the medication cart in the hallway without appropriately cleaning them. During an observation on 5/21/25 at 12:03 PM, LPN G took the same uncleaned glucometer that was sitting on top of the medication cart into room [ROOM NUMBER]-1 to check a blood sugar and left the room with the device and sat it on top of the medication cart without cleaning it. In an interview on 5/21/25 at 1:50 PM, LPN G reported she already knew she was supposed to clean the glucometer after each resident with sanitizing wipe with a purple top called Micro Kill Sanitizer Wipes for one minute and admitted she did not do that. At this time the glucometer and the blood pressure cuff were still sitting on top of the medication cart and LPN G reported she still did not clean them. LPN G did not know where the sanitizing wipes were and then searched the medication cart and found them. LPN G reported she had a total of 4 residents she had to use the glucometer for. LPN G reported she uses her own personal blood pressure cuff for resident care because she likes it better and realized she should have cleaned that as well after each resident. Hoyer lifts (continued on next page)

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	235039	A. Building B. Wing	05/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and an interview on 5/20/25 at 3:30 PM, two Hoyer lifts (mechanical lifts), numbered 203 and 309, were in the hallway of the 300 hall. Both lifts had empty plastic bags hanging from them. The base of one Hoyer lift was covered with a large amount of sticky and rough substance that did not rub off, while the upper bar where the slings attach was covered with fingerprints and grime. Certified Nursing Assistant (CNA) J stated that the empty bags were meant to hold sanitizing wipes for cleaning the lifts but acknowledged that there were none inside them. CNA J also noted that the feet of one Hoyer lift resembled tape. When I inquired about the bar above where the slings attach, CNA J indicated it appeared not to have been cleaned in a considerable time. Review of a policy titled Cleaning and Disinfection of Resident-Care Equipment last revised 8/24 revealed: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC (Centers for Disease Control) recommendations to break the chain of infection. 2. d. Multiple-resident use equipment shall be cleaned and disinfected after each use.