STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235094	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Samaritas Senior Living Cadillac	460 Pearl St Cadillac, MI 49601

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to ensure catheter securement devices were in place to prevent indwelling urinary catheter dislodgement for two residents (Resident #20 and Resident #64) of three residents reviewed for catheter care. Findings include: Resident #20 (R20) According to the Minimum Data Set (MDS) assessment dated [DATE], R20 scored 8/15 (moderately impaired cognition) on her BIMS (Brief Interview for Mental Status) assessment, and required extensive assistance with two person transfers. R20 was incontinent of bowel and had an indwelling catheter. Diagnoses for R20 included diabetes mellitus, anxiety, muscle weakness, and need for assistance with personal care. During an observation and interview on 8/13/24 at 12:10 PM, Registered Nurse (RN) C was performing a sacral wound dressing change for R20, who had a urinary catheter. R20 was observed with no indwelling catheter securement device in place. RN C stated, (R20) is dependent on staff for her cares. RN C acknowledged that R20 did not have a catheter secure device in place. RN C acknowledged there was no catheter securement device and stated, (R20) should have a catheter secure device on her leg to prevent the tubing from being pulled during cares or while she is being moved. Resident #64 (R64) According to the MDS, dated [DATE], R64 scored 13/15 (intact cognition) on the BIMS assessment, and required extensive assistance with two person transfers. R64 was incontinent of bowel and had an indwelling catheter. Diagnoses for R64 included urinary tract infection, benign prostatic hyperplasia. On 8/12/24 at 2:48 PM, R64 was observed lying in his bed. R64 was uncovered and wearing an incontinence brief. R64 had an indwelling urinary catheter that was visible and draped over his left leg connected to a urinary collection bag. R64's catheter tubing appeared taught. R64 was asked if they felt a pulling sensation where the tubing enters the body and replied, Yes, it is pulling. I can feel it pulling some. R64 was asked if there was ever a catheter securement device in place on the tubing and replied, I used to have one on my right leg, but it is not there anymore. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 7:45 AM, an interview was conducted with RN C and was asked if R64 should be wearing a catheter securement device and replied, Yes, let me check his orders. R64 lacked an order or intervention in the care plan for a catheter securement device. On 8/13/24 at 12:10 PM, an observation was made of R64 lying in bed. R64 was uncovered and wearing a brief and did not have a urinary catheter securement device on either leg. On 8/13/24 at 12:30 PM, an interview was conducted with the Director of Nursing (DON) and was asked if residents with indwelling urinary catheters were required to wear a catheter securement device and replied, Yes, all urinary catheters need a catheter secure, and the devices need to be used at all times. The DON was made aware that two residents were observed without catheter securement devices. On 8/14/24 at 10:05 AM, CNA E was observed performing catheter care on R64 in his room. R64 now had a catheter securement device in place. R64 was asked if the catheter secure device helped them not feel the pulling sensation described yesterday and replied, Yes, it feels much better now without the pulling. Review of policy titled, Catheters Care, dated 10/20, read in part, .It is the policy of this facility to provide catheter care to all residents that have an indwelling catheter .Policy explanation and compliance guidelines . 24.) Ensure that the catheter is secure to the leg every shift .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview and record review, the facility failed to ensure tube feeding was administered and dated per standards of practice to meet the nutritional needs of one Resident (R27) of one resident reviewed for tube feeding. Findings include: Review of R27's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including dysphagia, perforation of esophagus, and moderate protein-calorie malnutrition. On 8/12/24 at 11:15 a.m., R27 was observed in bed watching television with Jevity 1.5 [tube feeding formula supplying 1.5 calories per milliliter (mL)] infusing at 55 ml per hour (ml/hr). The Jevity 1.5 tube feeding formula bottle and the flush bag hanging above the tube feeding pump was undated and did not have nursing initials. On 8/13/24 at 8:47 a.m., R27 was observed in his bed sleeping with his tube feeding bottle dated 8/12/24 and his flush bag undated with no nursing initials. On 8/14/24 at 11:22 a.m., R27 was observed in his bed with his tube feeding bottle dated 8/13/24 and his flush bag undated with no nursing initials. Review of R27's Quarterly Nutrition assessment dated [DATE] read, in part, .(R27) is NPO (nothing by mouth) with enteral feeds via PEG (feeding tube that delivers nutrition to your stomach through your abdomen). Jevity 1.5 @ 55 ml/hr continuous with 50 ml water flushes q (every) 3 hours. This provides 1980 kcals (kilocalories) 84 g (grams) protein, 1000 ml free water from formula plus 400 ml water flush . Review of R27's Medication Administration Record (MAR) for August 2024 read, in part, Enteral Feed Order every 4 hours for NPO Jevity 1.5 55/hr continues with 50 ml water flush q 3 hours; start date 5/15/24. Review of this physician order showed no documentation of how much tube feed R27 received during a 24-hour period to ensure he was receiving the correct amount per his nutrition assessment. An interview was conducted with Registered Dietitian (RD) A and Charge Nurse/Registered Nurse (RN) D on 8/14/24 at 11:32 a.m. RD A stated that she made the recommendations for R27 to have his tube feed run every hour continuously and would expect that nursing staff was documenting how much tube feed R27 was receiving to ensure he had adequate nutritional intake. RN D stated that the physician order was placed in R27's MAR that way otherwise nurses would have had to check off they reviewed the tube feed every hour. RN D confirmed that R27's physician order was not documented correctly, and that staff should also be labeling and initialing R27's tube feed bottle and flush bag.

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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. 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 62 residents. Findings include: On 8/13/24 at approximately 11:45 AM, the steam table located in the kitchen was observed to have food ready for the noon meal. [NAME] B was asked if the food in the steam table was at proper temperature and ready to be served. [NAME] B stated it was. A stainless steel hotel pan containing what was identified by [NAME] B to be ground meat for the noon meal and was prepared for the specified ground texture diet. The temperature of the ground meat was measured with a Super Fast metal stem digital thermometer. Multiple locations within the ground meat product were measured to have temperatures of 112 F, 114 F, and 116 F. No internal areas of the food product were measured to be above 135 F. At approximately 11:55 AM [NAME] B was observed measuring the temperatures of the hot food located in the hotel pans in the steam table. Once [NAME] B had completed the measuring and recording the temperatures, [NAME] B was asked what temperature she had measured in the ground meat product. [NAME] B replied 147 degrees. [NAME] B was then requested to measure the temperature of the ground meat again with her thermometer. While observing the measuring task, [NAME] B was asked what her thermometer was reporting. [NAME] B stated between 114 F and 116 F. On 8/13/24 at 12:15 PM, an interview was conducted with Registered Dietitian (RD) A, with the above condition being discussed. RD A stated the food had been at the proper temperature when the product was placed in the steam table, approximately 10 minutes prior to the above observations of temperature measuring. When asked how it was possible that the temperature of a product, with the density of ground meat, could lose over 20 degrees while in a steam table, RD A stated I don't know. The FDA Food Code 2017 states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (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: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above; On 8/13/24 at approximately 7:30 AM, observations were made of the walk in cooler. A stainless steel pan with a label of goulash and a pan of scallop potatoes from the previous day (8/12/24) were observed on a cart. RD A was requested to show that the products had been properly cooled and documented. A book labeled cooling logs was found on a shelf in the food preparation area. A page was located with the date of 8/12/24 with entries of goulash and scallop potatoes. A initial time of 1:20 PM and temperature of 135 F were found documented. No additional tracking of the products was located. RD A stated the two pans of product would be disposed of. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The FDA Food Code 2017 states: 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 Based on observation, record review, and interview the facility failed to implement enhanced barrier precautions (EBP) for six residents (Resident #4, #20, #27, #39, #63, #64) of 24 sampled residents reviewed for EBP. This deficient practice has the potential for development and transmission of multi-drug resistant organism (MDRO) infections. Findings include: On 8/13/24 at 7:47 AM, during observations on the 200 and 400 unit, it was noted that no EBP signs were on resident doors for sampled residents who were identified as meeting criteria for EBP. These signs are used to alert staff to utilize personal protective equipment (PPE). There were also no carts located in these areas for the availability to store gloves, gown, and shields. (Staff are required to wear a gown and gloves during direct high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition such as residents with wounds or indwelling medical devices). High contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linen or briefs, device care or use: central line, urinary catheters, feeding tube, tracheostomy/ventilator or wound care. The following rooms were identified: a.) room [ROOM NUMBER]- Resident #20 (R20) b.) room [ROOM NUMBER]- Resident #64 c.) room [ROOM NUMBER]- Resident #4 d.) room [ROOM NUMBER]- Resident #63 e.) room [ROOM NUMBER]- Resident #27 (R27) f.) room [ROOM NUMBER]- Resident #39 On 8/13/24 at 2:10 PM, during an observation of a pressure ulcer wound care for R20 performed and assisted by Registered Nurse (RN) C and D failed to don PPE to abide by the EBP guidelines for wound care. On 8/14/24 at 8:00 AM, during an observation of a medication pass via peg tube for R27 it was noted that Licensed Practical Nurse (LPN) F did not don the proper PPE and failed to wear a gown during the entire process. On 8/14/24 at 10:05 AM, during an observation of a indwelling urinary catheter care performed by certified nursing assistant (CNA) E did not don proper PPE and failed to wear a gown during the entire process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with Infection Preventionist (IP) RN G, on 8/14/24 at 10:10 AM, she stated, RN G had read, and it was her understanding that EBP was discretionary in how the facility utilized it. This Surveyor asked for clarification of what she meant by discretionary. RN G stated, They utilize it for those suspected of infections or known infections, but have not utilized it for everyone with catheters, wounds, or feeding tube. RN G asked if we could speak with the Director of Nursing (DON) to gain her understanding. The DON voiced that they were utilizing EBP on residents with known or suspected infections, but not those residents without known infections. A review of policy titled, Enhanced Barrier Precautions, dated 2/23, read in part, . 1. c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. 2. Initiation of Enhanced Barrier Precautions: a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. ii. Infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precautions do not apply. 3. Implementation of Enhanced Barrier Precautions - a. Make gowns and gloves available immediately outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. b. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). c. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. e. Provide education to residents and visitors .