STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observations, interview and record review, the facility failed to ensure dignity and privacy for five residents (#9, #24, #27, #35, #37) of 18 residents reviewed for dignity and privacy, resulting in feelings of being dismissed, forgotten and embarrassment. Findings include: Dining: On 4/02/25, at 12:05 PM, an observation of main dining room lunch meal service was conducted. There were two residents sitting at a table together. At 12:10 PM, there was a tray offered to the one resident from the east hall tray cart. Resident #9 was sitting at the table and was overheard saying where's my food. In response, CNA K was overheard stating to Resident #9, one moment (Resident #9). At another table, a resident was served their lunch meal at 12:11 PM. Resident #37 was sitting across and was not served their meal. On 4/02/25, at 12:21 PM, Resident #9 and Resident #37 still had not been served their meals while the two residents sitting at their tables finished their meals and was assisted out of the dining room via their wheelchair and walker by CNA K. On 4/02/25, at 12:27 PM, the remaining residents still had not been served their meals. On 4/02/25, at 12:28 PM, a medal tray cart was pushed out of the kitchen into the dining room. The nursing staff passed the lunch meals to the remaining residents in an orderly manner. On 4/02/25, at 12:30 PM, a record review of the mealtimes that was posted on the dining room wall revealed East Hall Trays 11:45 AM . Dining room served 12:15 PM . On 4/02/25, at 12:50 PM, an interview with Registered Dietician (RD) B was conducted. RD B was asked why two residents were served their lunch meal, finished their lunch meals before all the other residents were served and RD B offered, they will chose to eat either in the dining room or their rooms. That is why their trays were on the East Hall tray cart. RD B was asked if that was a normal process for the tray pass and RD B offered, the aides should have let the kitchen know and they didn't as RD B was in the kitchen for the meal service. (continued on next page)

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 4/02/25, at 2:00 PM, a record review of Resident #9's electronic medical record revealed an admission on 11/26/2024 with diagnoses that included Diabetes, Legal Blindness and Anxiety disorder. A review of the Self-care performance deficit . care plan revealed . Interventions . EATING: (Resident #9) needs assistance with set-up all meals r/t blindness . A review of the most recent quarterly Cognitive Patterns assessment revealed Resident #9 had severely impaired cognition. On 4/02/25, at 2:15 PM, a record review of Resident #37's electronic medical record revealed an admission on 03/23/2023 with diagnoses that included bipolar disorder, schizoaffective disorder and other symptoms and signs involving cognitive impairment. A review of the most recent Annual Cognitive Patterns assessment revealed Resident #37 was moderately impaired cognition. On 4/03/25, at 8:29 AM, The Director of Nursing (DON) was alerted of the lunch meal pass observation the day prior. Resident #27: On 4/02/25, at 10:42 AM, surveyor knocked on Resident #27's door and entered. Resident #27 was lying in their bed with no clothes on. Surveyor quickly closed the door. Moments later, the door opened, and Resident #27 was again exposed with no clothes on. Once CNA I noticed surveyor, they quickly pulled the privacy curtain closed. Resident #27's door opened into their room. Their bed was closest to the hallway with an angle that could have exposed Resident #27 to the residents that were in the dining room across the hallway. On 4/03/25, at 10:45 AM, Unit Manager (UM) Q was alerted that Resident #27's privacy curtain was not closed while staff were performing cares. On 4/02/25, at 2:30 PM, a record review of Resident #27's electronic medical record revealed an admission on 11/28/2024 with diagnoses that included Anxiety, Depression and generalize weakness. A review of the most recent Cognitive Patterns assessment revealed Resident #27 had severely impaired cognition. A review of the self-care performance deficit care plan revealed . BED MOBILITY: 2 person assist . DRESSING: 2 person assist . On 4/03/25, at 8:43 AM, The DON was interviewed regarding the lack of privacy for Resident #27 on the day prior and the DON offered that both CNAS were written up and should know better. Call Lights: On 4/02/25, at 2:15 PM, a confidential group of residents complained their needs don't always get met and had the following voiced complaints: they will come in and turn off the call light and not come back (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they say they will come back but never do you have to put your call light on again and again they will cancel your light and say, I'll tell your aide what gets me is they say I'm not your aide, I cant do that they split the halls and 40's aide doesn't help 50's aide and vice versa when I turn my light on, in about 5 minutes they turn it off and then they forget about me they will say, I'll go get your aide and they can help you they will come back in an hour or so it upsets me I don't like it, I feel forgotten I feel left out I don't want to complain because they're probably busy with someone else it's hard to wait especially when you have to go to the bathroom 37666 Resident #35: Dignity On 4/01/2025 at 10:11 AM, while touring the end of the hall on the dementia unit outside room [ROOM NUMBER], it smelled strongly of urine. Upon entering the room, the smell of urine was even stronger. The smell was noted in the attached bathroom, near the doorway, and across the room. The smell had not been noted anywhere else in the hallway or in any other room. On 4/1/2025 at 11:20 AM, a housekeeper was observed cleaning in the hallway on the dementia unit. She was asked about the smell outside and inside room [ROOM NUMBER]. She said she had just cleaned in the room and bathroom. Upon entering room [ROOM NUMBER] with the housekeeper, the room smelled strongly of urine. The bathroom was entered, and it also had an overwhelming smell of urine. The housekeeper said she had mopped and cleaned both the bathroom and room earlier that day. There were no apparent stains on the floors. She was asked if the fall mats or bed had a urine smell, and it was difficult to determine if they smelled like urine because of the smell in the room. The resident (#35) was not in the room. On 4/1/2025 at 11:30 AM, Resident #35 was noted in the day room. Upon walking by him, there was no smell of urine. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #35 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, anxiety, history of intestinal cancer, and heart disease. 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 the resident needed some assist with all care. On 4/01/2025 at 2:15 PM, the Dementia unit was toured with the Director of Nursing/ DON and Corporate Nurse U. When room [ROOM NUMBER] was approached the door was closed. The door to room [ROOM NUMBER] was opened and the room continued to smell strongly of urine. With the door opened the hallway smelled of urine. The DON was asked how the room could smell like urine when it had been cleaned. She said both the current resident and resident in room next door urinate on the floor. Entered the room next door and it did not smell like urine. The DON said the resident previously in room [ROOM NUMBER] also urinated on the floor and said the floor had to be replaced. The floor in the room and bathroom appeared new and without stains. The Corporate Nurse said she also smelled it. The DON was asked what the plan was for the room, to remove the urine smell; she said they had previously thoroughly cleaned the room and would let me know what the plan was. On 4/02/2025 at 9:28 AM, room [ROOM NUMBER]-B continued to smell strongly of urine. The facility brought a cleaning plan for room [ROOM NUMBER]. They said the room was cleaned and an air purifier was added, and a new deodorizer was used. The cleaning plan was reviewed, and it said a new cleaning product that contained a deodorizer would be used along with the air purifier. 22347 Resident #24: Review of the Face Sheet, Minimum Data Set (MDS, resident assessment tool) dated 3/31/25, Physician orders dated 2023 through 2025, and care plans revealed resident #24 was [AGE] years old, admitted to the facility on [DATE], confused and not able to make his own healthcare decisions, and dependent on staff for Activities of Daily Living/ADL's. The resident's diagnosis included, hemiplegia and hemiparesis (flowing a brain bleed), Dysphagia (swallowing deficit), anxiety, major depression, weakness, and high blood pressure. During an observation on 4/2/25 at 11:40 a.m., Resident #24 was sitting on his bed toward the top and watching TV. The resident's call light that was laying on the floor at the bottom of his bed. When this surveyor asked the resident where his call was, he did not know, and he was unable to reach it when asked if he could get it. Review of the facility Promoting/Maintaining resident Dignity policy dated 10/26/23, stated All staff members are involved in providing care to residents to promote and maintain resident dignity and respect residents rights. Respond to requests for assistance in a timely manner (including access to call light to call for assistance).

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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** 37666 Based on observation, interview and record review, the facility failed to update and/or revise individualized, person-centered care plans to reflect changing care needs for 6 residents (#8, #14, #19, #28, #47, and #60) of 24 residents reviewed for care plans. Findings Include, Resident #28: Accidents On 4/01/2025 at 9:41 AM, Resident #28 was observed in the day room, sitting in a chair. The resident was awake and talkative, but confused. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #28 was admitted to the facility on [DATE] with diagnoses: Dementia, history of a stroke, hypertension, chronic pain, peripheral vascular disease, atrial fibrillation, weakness and unsteadiness on feet. The MDS assessments dated 11/27/2024 and 2/25/2025 revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 3/15 and needed assistance with all care including toileting. A record review of the Incident and Accident Reports for Resident #28 indicated from 11/14/2024- 3/22/2025 the resident had 8 falls: 11/14/2024, 12/6/2024, 12/7/2024, 12/12/2024, 12/20/2024, 2/22/2024, 3/4/2025, 3/22/2025. A review of the Care plans for Resident #28 indicated there was an Activities of Daily living/ADL care plan, but it did not mention toileting. Per the MDS assessment the resident needed assistance with toileting. A Fall Care Plan mentioned toileting the resident on 12/22/2024. The Fall Care Plans were not updated after the resident fell on [DATE], 12/6/2024 and 12/7/2024; the resident continued to fall. Resident #47: Accidents On 4/01/2025 at 11:45 AM, Resident #47 was observed pushing his wheelchair up and down the hallway on the Dementia unit. A record review of the Face sheet and MDS assessment indicated Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, history of falls with fracture, schizophrenia, anxiety, chronic pain syndrome, and heart disease. The MDS assessment dated [DATE] revealed the resident had severe dementia and needed some assistance with all ADL's including 1-person assist with toileting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Incident and Accident reports indicated Resident #47 had fallen 4 times from 11/1/2024 to 3/27/2025: 11/1/2024, 3/3/2025, 3/16/2025, 3/27/2025. A review of the Care plans for Resident #47 indicated the care plans were not reviewed, revised to prevent further falls after the 3/3/2025 and 3/16/2025 falls. The Fall Care plan was updated after the resident fell again on 3/27/2025. On 4/03/2025 at 9:08 AM, resident falls were reviewed with the Director of Nursing/ DON. Care plans were reviewed, as many of the interventions were routine nursing practice for example related to toileting: both Residents #28 and #47 had needed assistance with toileting prior to falling. Also reviewed the Care plans were not always reviewed or revised after the residents had fallen to try and aid in preventing future falls. Resident #60: Care Planning A record review of the Face sheet and MDS assessment indicated Resident #60 was admitted to the facility on [DATE] with diagnoses including: Dementia, Parkinson's disease, COPD, and heart disease. On 4/01/2025 at 2:57 PM during a review of the Advance directives including code status preferences, an assessment for the Code status could not be located in the medical record. On 4/02/25 at 12:52 PM, Social Services E was interviewed, and she identified a copy of the assessment form for Resident#60's Code Status preferences. Upon review of the resident's care plan, it did not specify the resident chose to be a Full code. It said, Honor residents advance care planning ., but did not specify what they were. 22927 Resident #8: Observation on 4/1/2025 between 9:00 AM and 10:00 AM during the initial screening process of Resident #8 was observed with silver metal bilateral half siderails in use. Resident #8 appeared confused and was not responding to questions related to the use of the siderails. Record review of resident #8's care plans pages 1- 46, noted a Falls/Injury related to contractures date 11/1/2024. Interventions identified: Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensure there are no trip hazards, providing assistive devices), Observe for changes in mobility, place call light within reach. There were no interventions or care plan that addressed the use/consent, assessment and monitoring of half siderails noted. Resident #14: Observation and interview on 04/01/25 at 09:05 AM of Resident #14 was noted to be lying in a large bed with silver metal Bilateral half side rails in use. The Resident stated that the siderails came with her bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #14's March 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) had no daily/weekly monitoring of bilateral half siderails for entrapment performed by nursing. Record review of resident #14's care plans pages 1- 20, noted a Falls/Injury related to contractures dated 3/14/2025. Interventions identified: Educate resident on safety interventions (none identified), Encourage resident to keep needed items within reach. Encourage resident to use call light. Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensure there are no trip hazards, providing assistive devices). There were no interventions or care plan that addressed the use/consent, assessment and monitoring of half siderails noted. Resident #19: Observation on 4/1/2025 between 9:00 AM and 10:00 AM during the initial screening process of Resident #19 was observed with silver metal bilateral half siderails in use. Record review of resident #19's care plans pages 1- 23, noted a Falls/Injury related to contractures dated 9/07/2023. Interventions identified: Educate resident on safety interventions (none identified), Encourage resident to keep needed items within reach. Encourage resident to use call light. Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensure there are no trip hazards, providing assistive devices), Transfer assist device enabler bar to bilateral of bed for increased mobility. There were no interventions or care plan that addressed the use/consent, assessment and monitoring of half siderails noted. Record review of Resident #19's 'informed Consent for Use of Bed Rails' form dated 2/20/2024 resident overview: What assessed medical needs would be addressed by the use of bed rails for this resident? Blank/no documented assessment. What are the possible benefits of bed rail use for this resident and what is the likelihood of these benefits? Blank/no documented assessment. What are the possible risks of bed rail use for this resident and how will these risks be mitigated? Blank/no documented assessment. Alternatives to bed rails have been attempted, but failed to meet the resident's needs, or were not attempted because they were considered to be inappropriate, describe: Blank/no documented assessment. Observation and interview on 04/02/25 at 12:02 PM with the Director of Nursing (DON) during a walking tour of the East unit rooms 40 through 56. The DON stated 'We don't have any siderails. We don't use them'. The DON walked with the state surveyor through the East hallway unit to observed rooms with half silver bed rails in place. Resident #14's bed observed with bilateral silver metal half side rails. Resident #19's bed observed with bilateral silver metal half side rails. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8's bed observed with bilateral silver metal half side rails. Resident #43's bed observed with bilateral silver metal half side rails. The Director of Nursing (DON) stated that those are assist bar's. Requested siderail policy. Record review of facility 'Comprehensive Care Plans' policy dated 6/30/2022 revealed it is the policy of this 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, and mental and psychosocial needs that are identified in the resident's comprehensive assessment (Minimum data Set).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review the facility failed to ensure accurate weights were obtained for 2 residents (#35 and #47) of 6 residents monitored for food or nutrition, resulting in Resident #35 and Resident #47 having inaccurate weights documented in the medical record. Findings Include: Resident #35: Nutrition A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #35 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, anxiety, history of intestinal cancer, and heart disease. 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 the resident needed some assist with all care. On 4/01/2025 at 11:40 AM, during a review of the weights for Resident #35 in the electronic medical record Weights/Vitals tab, it indicated the resident had a 16 lb. weight gain in one day. The resident weighed 162.0 lbs on 3/31/2025 and 178.4 lbs. on 4/1/2025 at 7:10 AM. On 4/1/2025 at 11:50 AM, Nurse O and Nurse Aide V were interviewed about the resident's weight gain of 16 lbs. in one day. Nurse O asked Nurse Aide V about the weight and asked her to reweigh Resident #35. On 4/1/2025 at 3:30 PM, Resident #35's weight was reviewed and a new weight of 160.3 was obtained by Nurse Aide V at 2:59 PM on 4/1/2025. The resident had not gained 16 lbs. He had lost 1.7 lbs. since the prior day. On 4/02/2025 at 1:04 PM, Registered Dietitian/RD B was interviewed about Resident #35's inaccurate weight of a 16 lb. weight gain in one day. Reviewed the resident's weight had not been checked against the prior weight or reweighed until the surveyor asked about the weight gain. The Dietitian said the staff had not checked the weight for accuracy and when she reviewed the residents, she would notice and ask them to reweigh the resident. She said she was in the facility a couple days a week and would check the weights at that time. Resident #47: Nutrition On 4/01/2025 at 11:45 AM, Resident #47 was observed pushing his wheelchair up and down the hallway on the Dementia unit. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Face sheet and MDS assessment indicated Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, history of falls with fracture, schizophrenia, anxiety, chronic pain syndrome, and heart disease. The MDS assessment dated [DATE] revealed the resident had severe dementia and needed some assistance with all ADL's. On 4/01/2025 at 11:49 AM, during a review of the electronic medical record Weight/Vitals tab it indicated Resident #47 weighed 1,830 lbs. on 4/1/2025 and 186.5 lbs. on 3/31/2025. The was a 1,643.5 lb. weight gain in one day. On 4/01/2025 at 11:58 AM, Nurse O and Nurse Aide V were interviewed about Resident #47's 1,643 lb. weight gain in one day. Nurse O said it must have been an error, and she asked Nurse Aide V to reweigh the resident. On 4/02/2025 at 1:05 PM, the 1,830 lb. weight for Resident #47 was reviewed with RD B and the resident was not reweighed until after the surveyor asked about it. The RD said she reviewed weights 3 days a week: Monday, Wednesday, Thursday and if she saw any abnormal weights, she would request a reweigh from the nursing staff. On 4/03/2025 at 9:00 AM, the Director of Nursing/DON was interviewed about Resident #35's inaccurate weight and she stated, We have a problem with weights. A review of the facility policy titled, Weight Monitoring, dated reviewed/revised 10/26/2023 provided, . Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem . A weight monitoring schedule will be developed upon admission for all residents: a. Weights should be recorded at the time obtained . Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight .

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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** 22347 Based on observation, interview and record review, the facility failed to ensure clean and dry storage of respiratory equipment for three residents (#25, #44, #54) of three residents reviewed for respiratory needs, resulting in unsanitary storage of respiratory equipment. Findings include: Resident #25: On 4/01/25, at 11:11 AM, Resident #25 was in their bed in their room. Their nebulizer mask was face down on their nightstand uncovered and without a barrier. Resident #25 was asked if they use their nebulizer and Resident #25 stated, yes. On 4/01/25, at 1:30 PM, a record review of Resident #25's electronic medical record revealed and admission on 2/05/2025 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and muscle weakness. A review of the self-care performance deficit care plan revealed Interventions . BED MOBILITY: 1 person assist . TRANSFERS : 1 person assist . On 4/02/25, at 9:35 AM, Infection Control (IC) Nurse A was asked how nebulizer masks should be stored when not in use and IC Nurse A offered, after cleaning and dried it goes back into the bag. Resident #44: On 4/01/25, at 9:42 AM, Resident #44 was resting in their bed. Their Continuous Positive Airway Pressure (CPAP) face mask was stored inside a medal basket on the back of the machine tower. The mask was uncovered. Their coughing machine mouthpiece and tubing was draped over the nightstand. The mouthpiece was in direct contact with the back of the oxygen concentrator. Resident #44 was asked if they were able to use their nebulizer mask and coughing machine independently and Resident #44, they help me with them. On 4/01/25, at 2:15 PM, a record review of Resident #44's electronic medical record revealed an admission on 12/17/2024 with diagnoses that included Amyotrophic Lateral Sclerosis (ALS), COPD and Obstructive Sleep apnea. A review of the self-care performance deficit care plan revealed Interventions . BED MOBILITY: 2 person assist . A review of the impaired pulmonary/respiratory status care plan revealed Interventions . Cough assist machine inhale 30cmh20 exhale-30cmh20 pause 2.0 seconds pap plus 5cmh20 therapy as ordered . CPAP: 6 Rate: 12 Machine as ordered . (continued on next page)

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Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/02/25, at 9:44 AM, IC Nurse A was alerted Resident #44's mouth piece was touching the back of the oxygen concentrator and the nebulizer mask was face down inside the medal basket uncovered and IC Nurse A offered, that is unacceptable. Resident #54: Review of the Face Sheet, MDS dated [DATE], nurses and social service notes dated 1/15 through 3/31/25, and care plans revealed, Resident #54 was [AGE] years old, alert, admitted to the facility on [DATE], and required assistance with ADL's. The resident's diagnosis included, cellulitis, anemia, diabetes, muscle weakness, acidosis, and a history of falls. The resident received respiratory treatments daily. Observation was made on 4/1/25 at approximately 9:45 a.m., of a clean and dry respiratory equipment (treatment mask) was sitting on the window seal on top of a clear plastic bag. During an interview done on 4/2/25 at 9:31 a.m., with Infection Control Nurse A, she stated You use a paper towel to sit it (treatment mask) on after it is cleaned (and dry), then it goes in the plastic bag. During an interview done on 4/2/25 at 9:30 a.m., the Director of Nursing stated we don't have a policy that say's put respiratory equipment in a plastic bag, but they should put it in a plastic bag after it's dry. 39059

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed complete assessments to determine the need for bed rails, monitor residents' continued use of bed rails, obtain physicians' orders, and implement care plans for 4 residents (#8, #14, #19, #43) and obtain consent prior to use for Resident #14, for 4 of 5 residents reviewed for entrapment. Findings include: Resident #8: Observation on 4/1/2025 between 9:00 AM and 10:00 AM during the initial screening process of Resident #8 was observed with silver metal bilateral half siderails in use. Resident #8 appeared confused and was not responding to questions related to the use of the siderails. Record review of resident #8' minimum Data Set (MDS) dated [DATE] revealed an elderly male with cognitive skills for daily decision making as severely impaired never/rarely make decisions. Medical diagnosis included: Dementia, cardiovascular accident (CVA), aphasia, hypertension, renal insufficiency, diabetes, seizure disorder and anxiety. Record review of Resident #8's electronic medical record of all the miscellaneous file folder under the heading of consents, revealed there was no consent or assessment found for the use of bilateral half siderails noted. Record review of resident #8's care plans pages 1- 46, noted a Falls/Injury related to contractures date 11/1/2024. Interventions identified: Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensure there are no trip hazards, providing assistive devices), Observe for changes in mobility, place call light within reach. There were no interventions or care plan that addressed the use/consent, assessment and monitoring of half siderails noted. Resident #14: Observation and interview on 04/01/25 at 09:05 AM of Resident #14 was noted to be lying in a large bed with silver metal Bilateral half side rails in use. The Resident stated that the siderails came with her bed. Record review of Resident #14's 5-day re-entry Minimum Data Set (MDS) dated [DATE] revealed an elderly female with cognitively intact able to make decisions. Medical diagnosis included: heart failure, cardiovascular accident (CVA), hypertension, renal insufficiency, pneumonia, urinary tract infection, diabetes, anxiety and depression. Record review of resident #14's 'Therapy to Nursing Communication Form' dated 2/25/2025 revealed that the resident was a two person assist with transfers via Hoyer lift with mobility device of wheelchair. There was no recommendation for bilateral half siderails noted. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #14's electronic medical record of all the miscellaneous file folder under the heading of consents, revealed there was no consent or assessment for the use of bilateral half siderails noted. Record review of Resident #14's April 2024 physician orders revealed there was no order for bilateral half siderails noted. Record review of Resident #14's March 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) had no daily/weekly monitoring of bilateral half siderails for entrapment performed by nursing. Record review of resident #14's care plans pages 1- 20, noted a Falls/Injury related to contractures dated 3/14/2025. Interventions identified: Educate resident on safety interventions (none identified), Encourage resident to keep needed items within reach. Encourage resident to use call light. Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensure there are no trip hazards, providing assistive devices). There were no interventions or care plan that addressed the use/consent, assessment and monitoring of half siderails noted. Resident #19: Observation on 4/1/2025 between 9:00 AM and 10:00 AM during the initial screening process of Resident #19 was observed with silver metal bilateral half siderails in use. Record review of resident #19's care plans pages 1- 23, noted a Falls/Injury related to contractures dated 9/07/2023. Interventions identified: Educate resident on safety interventions (none identified), Encourage resident to keep needed items within reach. Encourage resident to use call light. Ensure the resident's room is free from accident hazards (e.g., providing adequate lighting, ensure there are no trip hazards, providing assistive devices), Transfer assist device enabler bar to bilateral of bed for increased mobility. There were no interventions or care plan that addressed the use/consent, assessment and monitoring of half siderails noted. Record review of Resident #19's 'informed Consent for Use of Bed Rails' form dated 2/20/2024 resident overview: What assessed medical needs would be addressed by the use of bed rails for this resident? Blank/no documented assessment. What are the possible benefits of bed rail use for this resident and what is the likelihood of these benefits? Blank/no documented assessment. What are the possible risks of bed rail use for this resident and how will these risks be mitigated? Blank/no documented assessment. Alternatives to bed rails have been attempted, but failed to meet the resident's needs, or were not attempted because they were considered to be inappropriate, describe: Blank/no documented assessment. Resident #43: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/01/25 at 09:31 AM during the initial screening process of Resident #19 was observed with silver metal bilateral half siderails in use. Record review of Resident #43's 'informed Consent for Use of Bed Rails' form dated 7/2/2024 resident overview: What assessed medical needs would be addressed by the use of bed rails for this resident? Blank/no documented assessment. What are the possible benefits of bed rail use for this resident and what is the likelihood of these benefits? Blank/no documented assessment. What are the possible risks of bed rail use for this resident and how will these risks be mitigated? Blank/no documented assessment. Alternatives to bed rails have been attempted, but failed to meet the resident's needs, or were not attempted because they were considered to be inappropriate, describe: Blank/no documented assessment. The form did not identify the type (full/partial) or location (upper/lower) side rails to be used. Observation and interview on 04/02/25 at 12:02 PM with the Director of Nursing (DON) during a walking tour of the East unit rooms 40 through 56. The DON stated 'We don't have any siderails. We don't use them'. The DON walked with the state surveyor through the East hallway unit to observed rooms with half silver bed rails in place. Resident #14's bed observed with bilateral silver metal half side rails. Resident #43's bed observed with bilateral silver metal half side rails. Resident #8's bed observed with bilateral silver metal half side rails. Resident #43's bed observed with bilateral silver metal half side rails. The Director of Nursing (DON) stated that those are assist bar's. Requested siderail policy. In an observation and interview on 04/02/25 at 12:09 PM with regional maintenance support staff T observed resident rooms with silver half siderails and stated, Those are assisted bars for the larger residents to reposition. In an interview on 04/02/25 at 12:33 PM with the Nursing Home Administer (NHA) stated that they (silver half bed rails) are half bed rails. I immediately ordered one set of the assist bar to get the correct bars. The silver ones have been in the building forever. I saw the maintenance man carrying the silver half rails down the hall. I said what are you doing?. the state surveyor asked Why did you leave them on the beds? The NHA stated because we needed to have something with the intention of ordering the appropriate ones for the beds. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 04/02/25 at 12:50 PM with the Director of Maintenance F, stated The silver half siderails the facility had those already in the building. I took over the job last June 2024 as director of maintenance, Those Silver rails are what they have always used. I researched the correct rails, for the beds we have. I have ordered one set of assist rails, just to make sure it fits. I have siderail measurements. Director of Maintenance F and the state surveyor walked to the environmental office and received 'Bed Inspection Record' dated March 2023. That's the last time I did the siderails measurements and now the beds are not in the same rooms as back then. There were no other measurements documented, or information provided to the surveyor for the current bed siderails in use. Record review of the facility 'Proper Use of Bed Rails' policy dated 10/24/2022 revealed appropriate alternative approaches are attempted prior to installing or using bed rails . Resident assessment: .the following components will be considered when determining the resident's needs, and whether, or not the use of bed rails meets those needs: (a.) Medical diagnosis, conditions, symptoms, and/or behavioral symptoms, (d.) medications, (l.) cognition, (k.) communication, (k.) mobility . 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the residents' assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails: (a.) Accident hazards. (b.) Barrier. (c.) Physical restraint . Informed consent: Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails . Ongoing Monitoring and Supervision: This should be evidenced in the resident's records, including their care plan, including, but not limited to the following information: (a.) the type of specific direct monitoring and supervision provided during the use of bed rails, including documentation of the monitoring. (b.) The identification of how needs will be met during the use of the bed rails, such as for repositioning, hydration, meals, use of the bathroom and hygiene. (c.) Ongoing assessment to assure that the bed rail is used to meet the resident's needs. (d.) Ongoing evaluation of risks. (e.) The identification of who may determine when the bed rail will be discontinued, (f.) the identification and interventions to address any residual effects of the bed rail (e.g., generalized weakness, skin breakdown) On 4/3/2025 at 2:10 PM discussion during exit conference with the facility staff on updated bed rail measurements per unit manager, Nursing Home Administrator and Maintenance staff, they plan to copy list and upload into egress system for documents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to adequately monitor antibiotic use and update the antibiotic line listing for one resident (#2) of 17 sampled residents. Findings include: Record review of the facility provided CMS-802 MDS Resident Matrix dated 4/1/2025 at 9:36 AM revealed Resident #2 to have antibiotic medication and an indwelling catheter. Resident #2: Record review on 04/01/25 at 11:56 AM of Resident #2's March 2025 Medication Administration Record noted Gentamycin sulfate 10mg/ml, 27 milligrams miscellaneous every evening shift every Monday, Thursday, Saturday. Administer while in the shower on Monday and Thursdays. Mix with 50ml normal saline. Irrigate the bladder with 50ml through the suprapubic catheter and clamp for 30 minutes dated 2/8/2025. In an interview on 4/01/25 at 01:35 PM at Licensed Practical Nurse M stated that Resident #2 had Gentamycin solution flushed into the catheter, ordered 3 x week but resident only lets us do it 2 times a week during his showers. He will not take it on Saturdays and his mother is aware and so is his physician, although scheduled M-Th-Saturdays. In an interview and record review on 04/02/25 at 09:48 AM with the Registered Nurse (RN) Infection Control nurse A was asked about Resident #2's Gentamycin antibiotic monitoring. RN A record reviewed infection control line listings for the months of January, February, March 2025 revealed that the resident #2 was not included in the line listings and RN A stated that she was not aware of the resident #2 being left off the line listing. The state surveyor Requested infection line listing in paper format for the last 3 months. In an interview and record review on 04/03/25 at 08:58 AM with Registered Nurse (RN) Infection Control nurse A stated there is no line listing of Resident #2's gentamycin antibiotic medication since 2023, Record review I was digging into his medical record and there was no line listing of the Gentamycin antibiotic for Resident #2 in his urinary catheter, flush & clamp. Resident #2 is colonized, but the urologist ordered the med, indefinitely. Order started in 2023. In June 24,2024 he had labs done. Record review of the 2024 infection control line list binder revealed Resident #2's gentamycin was not listed on any of the line listings for antibiotic monitoring and tracking. Monitoring the antibiotic use, we are not monitoring, we should be monitoring because of MDRO's will grow and we do not need any more of those. The state surveyor asked if the treatment effective and appropriate. RN A stated that by the looks of Resident #2's labs I think that it's not effective. I cannot get [NAME] lab to do stewardship forms. The state surveyor asked about why not on the monthly Line listing? RN A stated Yes, it should be on the line listing every month, and from now on it will be.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to ensure medication labeling, storage and discard of medications in 4 of 4 medication carts reviewed, resulting in a lack of dating of multi-dose medications with specified time frames for use after opening. Findings include: Observation and interview on [DATE] at 08:01 AM on the [NAME] unit medication cart with Licensed Practical Nurse (LPN) P revealed that: Unsampled female resident had Trelegy Ellipta 100mcg/62.5mcg/25 mcg multi-dose medication, opened/used and not dated with either open date or expirations date once opened. Resident #67- Ipratropium Bromide Inhalation 0.02%, ampules located within the box not in the foil packet. Resident #52- Ipratropium Bromide and Albuterol Sulfate 0.5mg & 3mg/3ml. 3 ampules located in box and not in foil packets. LPN P stated that the ampules are to be in the foil packets not loose. [NAME] with green lettering open and expiration date stickers on some medications were noted by the surveyor. Observation, interview and record review on [DATE] at 08:22 AM of the secured dementia unit medication cart with Licensed Practical Nurse (LPN) O revealed that: Resident #53 had glargine injection pen opened/used date [DATE] with no expiration date on pen noted. (Open 29 days, expired at 28 days). Unsampled male resident- Lantus Solostar pen/used open date [DATE] no expiration date on pen. Unsampled female resident- glargine injection insulin pen open date [DATE], no expiration date noted on pen. licensed Practical Nurse (LPN) O stated We are supposed to write the expiration dates on the insulin pens, and they are only good for 28 days or shorter, when we open them, we date them with the open and expiration date. Record review of the 'Stability of Common Insulin's in Vials and Pens' forms located within the secured dementia unit narcotic binder identified shortened expiration dates for insulin pens and bottles of glargine insulin. Observation and interview on [DATE] at 08:51 AM of the East Wing (,d+[DATE] rooms) medication cart with Registered Nurse (RN) N revealed: Resident #27- Nitro glycerin sublingual 0.4mg with red sealed tape missing with no open date or expiration date found on bottle or pharmacy medication container. Observation of blood glucose strips bottle of 50 strips opened with no date. State surveyor observed 15 strips in bottle, of a 50-count bottle. RN N stated that the glucose strips were Good for 30-days after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on [DATE] at 08:40 AM of East unit medication cart rooms ,d+[DATE] with licensed Practical Nurse (LPN) M revealed that: Observed one loose white tablet in the second drawer of the cart. Resident #14- Latanoprost 0.05% Ophthalmic drops open/used date of [DATE] with no expiration date noted on the bottle. licensed Practical Nurse (LPN) M accessed the computer and looked up the medication Latanoprost 0.05% Ophthalmic drops that once opened used in time frame of 6 weeks. Surveyor requested ophthalmic medications open date policy. Record review of the facility-provided 'Medication Storage' policy, dated [DATE], revealed it was the policy of the facility to ensure all medications housed on the premises are stored according to the manufactures recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. (6.) Light protection: All drugs, which require light protection while in storage, remain in the original package . Record review of facility-provided 'Medications and Biological's labeling of' policy, dated [DATE], revealed all medications and biological's used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. (8.) labels of multi-use vials must include: (a.) the date the vial was initially opened or accessed. (b.) All opened or accessed vials should be discarded within 28 days unless the manufacture specifies a different (shorter or longer) date for that opened vial. In an interview and record request on [DATE] at 11:37 AM, the Nursing Home Administrator (NHA) was asked about a multi-dose medication policy? NHA stated no. NHA was asked about Open medication and expiration date policy? NHA stated, no, we do not have that either. An interview and record review on [DATE] at 9:30 AM with the infection control preventionist/Staff education/registered Nurse (RN) A revealed that there it was no ophthalmic medication policy. RN A was to call the pharmacy and ask about the expiration once open Latanoprost 0.05% expectation. At the end of the survey no further documents were provided for this concern.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility failed to ensure an adequate amount and choice of evening snacks for a Confidential Group of residents reviewed, resulting in not getting snacks, enough snacks, feeling left out for a choice of snacks and an overall feeling of frustration. Findings include: On 4/2/25, at 2:15 PM, a confidential group of residents complained the facility doesn't restock the snack carts and the snack items are always the same. The following complaints were voiced: they don't pass snacks at night they took away the snack cart they only give us peanut butter and jellies, and that's if there are any left sometimes we get apples and oranges, but not often it would be nice if we could grapes we want more fruit choices there is a difference between center snack cart and west snack cart meat sandwiches are few and far between we don't get the refrigerator things we don't get certain snacks unless we get them before the kitchen closes we want egg salad, tuna and more meat sandwiches it would be nice to get Oreo cookies or Doritos we only get fudge rounds or oatmeal cookies we want different kind of chips, its always the same kinds we need more protein choices, like cheese if there isn't any peanut butter and jellies on the cart, your screwed (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	we want cool whip on our Jello On 4/03/25, at 9:10 AM, Dietary Aide J was interviewed regarding the snacks available and the facility process on providing snacks. Dietary Aide J offered, we have snack carts that go out at 8:30 PM when the dietary staff leave and we put cold items into the nourishment refrigerator. On 4/03/25, at 9:15 AM, an observation of the nourishment refrigerator that housed the snack items was conducted with Dietary Aide J. There was one 5 and half ounce clear plastic container of cottage cheese, one Jello and numerous puddings. Dietary Aide J was asked what protein type snacks do they provide in the evening and Dietary Aide J offered, cottage cheese is our protein. Dietary Aide J was asked how many cottage cheese snacks are placed in the refrigerator and Dietary Aide J offered, about 4 or 5 and the same amount of puddings, meat sandwiches and apple sauce. On 4/03/25, at 9:20 AM, an observation of the kitchen stock for snack items was conducted with Dietary Aide J. The dry storage housed the following snack items: 15 boxes of oatmeal pie cookies, 7 boxes of fudge rounds, 1 box of assorted chips (sour cream and onion, barbeque, plain and corn chips), graham crackers, a case of unopened fig cookies, two boxes of Oreo cookies and a case of bananas. The preparation refrigerator was observed to have opened bologna and ham, a large container of American cheese slices and a container with a few boiled eggs. Dietary Aide J was asked if they make egg salad sandwiches and Dietary Aide J offered, if we have eggs left over. Dietary Aide J was asked if they ever make tuna fish sandwiches for snacks and Dietary Aide J offered, if we get the large cans of tuna in. An observation of the snack carts that were in the kitchen was conducted with Dietary Aide J. There were two snack carts. Dietary Aide J was asked what items get stocked on the carts and Dietary Aide Joffered, chips, cookies, apple sauce, bananas. Dietary Aide J was asked how many of each snack items are placed on the cart and Dietary Aide J offered, about 4 or 5 of each. There were clear plastic containers that housed peanut butter and jelly sandwiches that were cut in half. Dietary Aide J was asked how many peanut butter and jelly sandwiches are made for the snack carts and Dietary Aide J offered, they do a loaf of bread each day, cut them in half and place them on the cart. Dietary Aide J was asked why the fig cookies were unopened and Dietary Aide J offered, we just got them Tuesday. Dietary Aide J was asked how many Oreo cookies are placed on the carts and Dietary Aide J offered, well, it's a new item so they get picked over fast. On 4/03/25, 9:54 AM, Dietary Manager G was asked to provide their evening snack list for the residents and if there was a kitchen key available once the kitchen staff leave for the night and Dietary Manager G shook their head no, and offered, because we stock the nourishment room. On 4/03/25, at 11:00 AM, a record review of the Resident Council Minutes provided by the facility revealed the following: 1-7-25 . Old Business Review: (List unresolved old business from last meeting's .) Issue . Snacks not being passed Status . Update Ongoing . 12/10/24 . Current Situation/Concern . Snacks are not being offer . Person Responsible . Nursing . A record review of the facility provided Snack list: Nutritional Room revealed the following items listed: 4-5 yogurt (continued on next page)

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	235175	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4-5 Cottage cheese 4-5 pudding 1 carafe orange juice 1-2 pictures of lemonade 4-5 meat sandwiches Any other requested by residents It is filled in am and again at 4pm Snack Carts Each cart has these items: Around 9 peanut butter & jelly sandwich Containers with Fudge rounds oatmeal pies Oreo [NAME] Doone's Fig [NAME] variety of chips [NAME] crackers saltines Cheeze it Applesauce Banana's Oranges

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22347 Based on observation, interview and record review, the facility failed to 1) Maintain food preparation and kitchen equipment in a sanitary and good working condition and 2) Maintain a correct thawing procedure for hamburger. Findings Include: Review of the Public Health Service 2009 Food Code, adopted by the Michigan Food Law, effective October 1, 2012, Chapter 4-501.14 directs that equipment cleaning frequency is to be throughout the day at frequency necessary to prevent recontamination of equipment and utensils. Review of the facility Food Receiving and Storage policy dated 1/1/2022, revealed food items open and partly used need opened on and use by dates. On 4/1/25 at 8:00 a.m., a kitchen walk through was done accompanied by [NAME] C. The following concerns were identified during the walk through: -At 7:55 a.m., observation of the large can opener sitting on the food prep table was noted sitting on the food cart to have dried on food on the blade and around the blade was found to also have dried food on it. -At 8:00 a.m., observed the small toaster with an excessive amount of crumbs. During an interview done on 4/1/25 at 8:00 a.m., [NAME] C said they only use the small toaster for glutton free toast. -At 8:07 a.m., the large mixer was observed to have dried-on batter like substance on the attachment directly above the mixing bowel. -At 8:08 a.m., the plate warmer was observed to have dried on food drippings on the inside next to were clean plates wound be. -At 8:10 a.m., the black food cart with plastic bowels on it and cereal, was found to have food on the all the 3 shelves and 3 black plastic bowels were found to have dried on food inside. -At 8:15 a.m., in the freezer, was observed a log of hamburger sitting in an extensive amount of blood. During an interview done on 4/1/25 at 8:15 a.m., [NAME] C said she did not know if leaving thawing meat in a pool of blood on a tray was ok. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 4/2/25 at 9:31 a.m., Infection Control Nurse, RN A stated This is extremely wrong; first of all food borne illness, once it thaws it generates bacteria. It's like a Petri dish growing. -At 8:30 a.m., Observation of the gray plastic food tray cart was found to have dried on food and drippings on it. This cart is where clean food trays are put. -At 9:00 a.m., a small brush was observed on the hand washing sink. This can transfer bacteria from staff to staff during use. During an interview done on 4/1/25 at 9:16 a.m., Dietary Aide/Cook J stated We use it (the small brush) for my nails when I wash my hands. Review of the facility Food Preparation and Service policy dated 1/1/22, stated Potentially hazardous foods (PHF), including raw meats, which might contaminate other foods or the food preparation area, will be prepared in specified areas using appropriate measures to prevent cross contamination. This policy included Thawing Frozen Food. During an interview done on 4/2/25 at approximately 11:00 am. with registered dietitian/RD B,she verbalized the hamburger loaf should not be sitting in blood; the meat should be on a clean pan, it's a cross contamination issue. RD B said this will increase bacteria and has the potential for illness. Review of the facility Infection Control walk through Validation Checklist Kitchen Observation sheet dated 1/23/2025, revealed #3 meat thawing was satisfactory. Review of this check list for 1/25, revealed everything checked off was satisfactory, no concerns were found. During an interview done on 4/3/25 at 8:50 a.m., RD B gave this surveyor a dietary staff education done on 4/1/25 (after the observation made of hamburger thawing sitting in blood), with signatures regarding proper thawing technique. The dietary education stated When meat is thawing, if blood begins to pool excessively under thawing meat, change drip pan. Changing drip pan will prevent the potential of cross contamination. Review of the facility Supervisor Dietary Job Description (un-dated), stated Provides training, direction and guidance for the dietary staff (including proper thawing technique).

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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** 22347 Based on observation, interview and record review, the facility failed to ensure that fans were clean for Resident #41 and Resident #54 and oxygen tubing was stored appropriately for Resident #42. Findings Include: Resident #41: Review of the Face Sheet, MDS dated [DATE], nurses and social service notes dated 1/25 through 4/1/25 through, and care plans revealed Resident #41 was [AGE] years old, alert, admitted to the facility on [DATE], and required assistance with ADL's. The resident's diagnosis included, history of Guillain-Barre Syndrome, anemia, pulmonary embolism, diarrhea, encephalopathy, muscle weakness, depression, and anxiety. Observation done on 4/1/25 at approximately 9:45 a.m., revealed Resident #41's black fan on high blowing directly on him with an extensive amount of dust blowing on the front and back cover. During a second observation made of the Resident #41's done on 4/2/25 at 12:09 p.m., he was sitting on his bed and his fan was observed blowing on high directly toward the him. It had not been cleaned from observation made on 4/1/25, the front cover of the fan was covered with dust on the front and back cover, blowing dust towards the resident. During an interview done on 4/2/25 at 12:09 p.m., Resident #41 stated No, no one has cleaned my fan. During an interview done on 4/3/25 at 9:30 a.m., the Director of Nursing/DON stated, There is no policy for cleaning fans. During an interview done on 4/3/25 at 11:35 a.m., the Administrator stated, it's Housekeeping who cleans the fans. Review of the facility generalized cleaning policy; revealed there was no documentation stating exactly who is responsible for cleaning the fans. Resident #42: Review of the Face Sheet, MDS dated [DATE], Nurses and Social Service notes dated 3/25 through 4/1/25, and care plans revealed, Resident of #24 was [AGE] years old, admitted to the facility on [DATE], confused and able to make healthcare decisions, and required assistance with ADL's. The resident's diagnosis included, chronic lung disease, heart disease, history of a fracture of the neck, dementia, high blood pressure, falls, anxiety, and oxygen dependence. On 4/1/25 at 12:12 p.m., observation was made of the resident in his bed and his oxygen tubing connected to the nasal cannula was hanging over his wheelchair and the NC was not in a bag for prevention of cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 4/3/25 at 11:50 a.m., the Director of Nursing stated, We don't have a policy for respiratory equipment (including oxygen tubing connected to a nasal cannula) stored in a bag (when not in use). During interviews done on 4/3/25 at 12:00 p.m., with Nursing Assistant/CNA S and CNA R said it is the responsibility of the Aides (CNA's) to make sure our residents oxygen tubing is in a bag when not using. Resident #54: Review of the Face Sheet, MDS dated [DATE], nurses and social service notes dated 1/15 through 3/31/25, and care plans revealed, Resident #54 was [AGE] years old, alert, admitted to the facility on [DATE], and required assistance with ADL's. The resident's diagnosis included, cellulitis, anemia, diabetes, muscle weakness, acidosis, and a history of falls. The resident received respiratory treatments. Observations made on 4/1/25 at 9:15 a.m., revealed Resident #54 in his bed with a Nurse, P giving him his medications via feeding tube. A medium size black fan was blowing directly on resident, and it had dust on the cover; at the time the resident was in his bed and the fan was blowing directly towards him. Also, a 1/4 full urine catheter bag was observed hanging on the black trash bin that had trash in it. Nurse P was standing right by catheter bag hanging on the trash bin; she left the resident's room and did not empty the urinal nor move the catheter bag off of the trash bin. During an interview done on 4/2/25 at 9:31 a.m., Infection Control Nurse, RN A stated Urinals, the nurse should have immediately taken the urinal and dumped it. During a second observation done on 4/2/25 at 12:04 p.m., the resident was in his bed with the same fan blowing on him. The fan was on high and had not been cleaned, it still had dust blowing on the front cover.