STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Manor Healthcare Center	730 Kimole LN Adrian, MI 49221

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 45038 Based on interview and record review the facility failed to provide timely financial statements to one Resident (#26)/responsible person of one Resident reviewed for Resident trust fund, resulting in the resident/responsible person being not informed about personal funds. Findings Included: Resident #26 (R26) Review of the medical record revealed R26 was admitted to the facility 05/25/2017 with diagnoses that included Liver cirrhosis (chronic liver damage resulting in liver failure), type 2 diabetes, osteoarthritis right elbow, hepatic failure (liver failure), protein-calorie malnutrition, pain of right shoulder, alcohol dependence, schizoaffective disorder, abnormal gait, muscle weakness, heart disease, heart failure, dementia, gastro-esophageal reflux, depression, hypotension, chronic respiratory failure, history of myocardial infarction (heart attack), hypertension, urinary retention, and chronic viral hepatitis C. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/05/2024, revealed a Brief Interview for Mental Status (BIMS) of 1 (severe cognitive impairment) out of 15. During a telephone interview on 07/09/2024 at 10:43 a.m. R26's Family Member E explained that he was the Durable Power of Attorney (DPOA) of R26. R26's Family Member E explained that the facility managed R26's financial matters. R26's Family Member E denied every receiving a quarterly financial statement from the facility. R26's Family Member E explained that R26 had a financial account at the facility but again denied receiving a quarterly statement of R26's account balance or activities. In an interview on 07/10/2024 at 02:52 p.m. Business Office Manager (BOM) H explained that residents were allowed to have a financial account that was to be held by the facility and that the money was placed in an interest-bearing account. BOM H explained that the facility used a third-party contractor for the management of resident accounts and statements were mailed to the facility. After the financial statements are received by the facility they are mailed to the resident/responsible persons. When asked for documentation demonstrating that R26's Family Member E had been mailed a quarterly statement, she was unable to provide documentation. BOM H then explained that the facility has not received quarterly statements from the third-party or mailed statements to the residents/responsible party for an undetermined amount time. BOM H could not explain when the last time financial statements were mailed to R26's Family Member E (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lynwood Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 730 Kimole LN Adrian, MI 49221	

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R26's financial statement revealed R26 had a current balance of $672.67, demonstrating that R26/R26's Family Member E should have been receiving quarterly financial statements.

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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 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** 38383 This citation pertains to intake MI00144424. Based on observation, interview and record review, the facility failed to notify the Physician of a change in tissue appearance for a hot liquid thermal burn for one (Resident #28) of one reviewed. Findings include: Review of the medical record reflected R28 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included multiple sclerosis and unspecified severe protein-calorie malnutrition. The significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/23/24, reflected R28 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was coded for second or third degree burns. During an interview and observation on 07/09/24 at 2:17 PM, R28 reported about three to four months prior, hot coffee fell over and was super hot. He reported having a fourth-degree burn on his leg. He lifted the left leg of his shorts and showed a darkened area, several inches long, on the lateral (outside) aspect of his left leg. R28 reported there was a lid on his cup, which he had next to him, in his wheelchair. According to R28, the lid did not seal good enough, causing the hot coffee to leak out of the side of the cup. R28 reported when the coffee spilled on him, he told staff right away, and they put stuff on to make it heal. An incident report for 4/18/24 at 11:17 AM, reflected R28 came up to the nurse, stating he had spilled coffee on himself and the floor. His left thigh was assessed and noted to have blisters and a raised, red area. The immediate action taken reflected the burn was cleansed, then iced for 20 minutes. Once the ice was off, medihoney (wound and burn treatment) was applied to the wound, then covered with an ABD dressing. During an interview on 07/10/24 at 2:59 PM, Licensed Practical Nurse (LPN) L reported being R28's nurse at the time he sustained the coffee burn. R28 came to her and reported receiving coffee from the kitchen, which he put in the side of his wheelchair. When he went outside, the coffee spilled on his leg and burned him. LPN L reported the burn initially appeared as the length of her cell phone, with a large blister. When she saw the burn the following week, the blister was no longer intact, and there was raw skin. According to Mayo Clinic, .2nd-degree burn. This type of burn affects both the epidermis and the second layer of skin (dermis). It may cause swelling and red, white or splotchy skin. Blisters may develop, and pain can be severe. Deep second-degree burns can cause scarring .3rd-degree burn. This burn reaches to the fat layer beneath the skin. Burned areas may be black, brown or white. The skin may look leathery. Third-degree burns can destroy nerves, causing numbness . (https://www.mayoclinic.org/diseases-conditions/burns/symptoms-causes/syc-20370539). (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24, R28's burn measured 20 centimeters (cm) in length by (x) 7 cm in width. The wound photo revealed a red, raised area with intact blisters. R28's pain level was recorded as eight out of ten. On 4/22/24, R28's burn measured 20 cm in length x 7 cm in width. The burn was staged as partial thickness (affects the top two layers of the skin). The tissue type reflected, Necrotic [dead tissue] Soft, Adherent=50%, Necrotic Hard, Firm, Adherent=50%. R28's pain level was recorded as eight out of ten. The assessment reflected the burn was Very painful. R28's burn was evaluated by the Wound Provider on 4/25/24. The assessment reflected R28 had a second-degree burn, measuring approximately 18 cm in length x approximately 6 cm in width and 0.1 cm in depth. The tissue was 75% slough (non-viable tissue that can present as yellow, tan, gray, green or brown) and 25% granulation (pink/red tissue that fills a wound when it begins to heal). R28's treatment was changed to silvadene (cream used to prevent and treat infections for people with burns). During an interview on 07/11/24 at 10:01 AM, Assistant Director of Nursing (ADON) R reported seeing R28's burn the day it happened. She reported the burn extended into the fatty layer of skin and was classified as a second-degree burn. ADON R reported that R28's burn had more dead tissue and was appearing more like a third-degree burn when she assessed it on 4/22/24. ADON R acknowledged she did not see any documentation in R28's medical record pertaining to notifying the Physician about the change in R28's burn appearance on 4/22/24. She reported she thought medihoney was still the appropriate treatment as of her assessment on 4/22/24. When R28 was seen by the Wound Provider on 4/25/24, the treatment was changed to silvadene.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 45038 Based on interview and record review the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) for one Resident (#14) out of three reviewed for Beneficiary Notification. Findings Included: Resident #14 (R14) Review of the medical record revealed R14 was admitted to the facility 02/08/2024 with diagnoses that included type 2 diabetes, weakness, difficulty walking, repeated falls, lack of coordination, dysphagia (difficulty swallowing), severe protein-calorie malnutrition, hypertension, hyperlipidemia (high fat content in blood), hypothyroidism (low thyroid hormone), heart disease, depression, chronic obstructive pulmonary disease (COPD), and shortness of breath. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/17/2024, revealed a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. Review of R14's medical record demonstrated that his payment source was changed from Medicare to pending Medicaid on 03/07/2024. Review of the SNF (Skilled Nursing Facility) Beneficiary Notification Review (completed by the facility) revealed that the facility did not provide R14 with an Notice of Medicare Non-Coverage (NOMNC) and did not provide R14 with a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) prior to his last day of Medicare Part A Services which was 03/06/2024. In an interview on 07/11/2024 at 09:38 a.m. Social Worker (SW) C explained that he was responsible to provide resident with Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) and Notice of Medicare Non-Coverage (NOMNC) letters once a the resident no longer qualified for Medicare Services and wished to stay in the facility. SW C could not explain why the SNFABN and the NOMNC were not provided to R14.

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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. 30337 Based on observation, interview, and record review the facility failed to provide wound care per physician orders, in one of two residents reviewed for non-pressure wounds (Resident #29), resulting in the likelihood of infection, and delayed wound healing. Findings include: Resident #29 (R29) R29 was observed on Tuesday, 7/09/24 at 10:09 AM, sitting in his room in his wheelchair with dressings on each arm that were heavily saturated with brown drainage and both dressings were dated 7/04/24. R29's Minimum Data Set (MDS), with assessment reference date of 6/28/24, introduced a Brief Interview for Mental Status (BIMS, a brief cognitive screener) score of 15 (13-15 Cognitively Intact). The same MDS indicated he had the diagnoses of heart failure, high blood pressure, end stage renal disease requiring dialysis, lung disease, skin tears, and moisture associated skin damage. In review of R29's physician orders dated 7/01/24, instructions were to cleanse wounds on his left forearm and right elbow with wound cleanser, pat dry, apply Medi honey (aids in promoting moist wound environment and supports debridement), cover with a Telfa dressing, and secure with Tegaderm dressing every Monday, Wednesday, and Friday for wound care. In review of R29's June 2024's Treatment Administration Record (TAR), the left forearm and right elbow wound treatments were signed out as completed on Friday, July 5, 2024. The same TAR, on Monday, 7/08/24, indicated to other/see progress notes. In review of R29's progress notes dated 7/08/24, there was no information documented explaining why the wound dressings to R29's left forearm and right elbow were not changed per physician orders. Registered Nurse (RN) Z was interviewed on 7/10/24 at 1:40 PM and stated he did not recall if he changed R29's dressings on Friday, 7/05/24. Licensed Practical Nurse (LPN) M was interviewed on 7/10/24 at 1:52 PM and stated she did not change R29's dressings on Monday, 7/08/24 because the Assistant Director of Nursing (ADON) completed wound observations and dressing changes on Mondays. LPN M stated she documented a 9 to not be flagged red in the electronic medical record as not completed. ADON R was interviewed on 7/10/24 at 2:21 PM and stated she didn't have staff assisting with her wound rounds on 7/09/24 and did not complete R29's treatments.

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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** 30337 Based on observation, interview, and record review, the facility failed to provide restorative ambulation services to maintain mobility, in one of one resident reviewed for mobility (Resident #4), resulting in sadness and fear of loss of ability to walk. Findings Include: Resident #4 (R4) R4 was observed sitting in a wheelchair in her room on 7/09/24 at 12:21 PM and 7/10/24 at 10:25 AM; and during an interview stated she wanted to participate in therapy, but insurance would not cover it. R4 stated she used to be able to walk, staff were supposed to walk with her up and down the hall; but staff did not let her walk outside of her room. R4's Minimum Data Set (MDS) assessment with assessment reference date (ARD) of 6/19/24, revealed she was [AGE] years old, had a Brief Interview for Mental Status (BIMS, short cognitive screener) score of 14 (13-15 Cognitively Intact) and had the diagnoses of traumatic brain injury, history of a stroke with hemiplegia (complete or severe paralysis on one side of the body including face, arm and leg), seizure disorder, anxiety and depression. The same MDS indicated R4 had functional limitations in range of motion (ROM) on one side of both upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. Certified Nurse Assistant (CNA) W was interviewed on 7/10/24 at 10:24 AM and stated R4 was independent for mobility in her room and did not supervise/assist her to walk outside of her room. Director of Nursing (DON) B was interviewed on 7/10/24 at 8:51 AM and stated the facility did not have a restorative nursing program, that the nurse assistant would walk with the resident or complete other restorative nursing activities with activities of daily living (ADL) care. DON B stated if the residents mobility declined, they would be referred to therapy. Physical Therapy Discharge Summary dated 12/20/23 revealed R4 received skilled services for strength training, standing, gait and balance training. R4 was able to ambulate 10 feet independently and 150 feet with supervision or with touching assistance. R4 was independent in her room for transfers and mobility. Rehabilitation Director Y was interviewed on 7/11/24 at 8:41 AM and stated it was recommended R4 ambulate with staff in the hallway, there was not a restorative nursing program, and he had instructed nurse assistants to assist R4 with ambulation in the hall following discharge from physical therapy. Occupational Therapy (OT) Discharge Summary dated 5/28/24 revealed recommendations for R4 to have supervision or touching assist with transfer to the toilet and with toileting hygiene. In review of R4's Kardex (CNA care plan), dated 7/10/24, there were no instructions to ambulate R4 in the hallway. R4's same Kardex indicated she was independent with transfers and toilet use. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON B was interviewed on 7/10/24 at 11:05 AM and stated she would look into why R4 did not have a walking program. CNA X was interviewed on 7/11/24 at 8:36 AM and stated there were no residents on her assignment, that included R4, that were to be supervised/touch assistance for walking in the hallway. CNA Q was interviewed on 7/11/24 at 8:58 AM and stated CNA's don't walk any residents on 200 hall. On 7/11/24 at 12:36 PM, R4 was observed lying in bed and stated not walking made her feel horrible and sad; and I'm scared I'm going to lose everything.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation has two Deficient Practice Statements (DPS), A and B: DPS A: This citation pertains to intake MI00144424. Based on observation, interview and record review, the facility failed to ensure hot liquid was served at a safe and appropriate temperature for one (Resident #28) of three reviewed for accident hazards, resulting in Immediate Jeopardy when R28 received coffee of an unknown temperature, which spilled, causing R28 to sustain a second-degree thermal burn (damage to outer and second layer of skin, causing blisters, pain and discoloration) on his left outer thigh and increased pain. Findings include: Resident #28 (R28): Review of the medical record reflected R28 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included multiple sclerosis and unspecified severe protein-calorie malnutrition. The significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/23/24, reflected R28 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was coded for second or third degree burns. During an interview and observation on 07/09/24 at 2:17 PM, R28 reported about three to four months prior, hot coffee fell over and was super hot. He reported having a fourth-degree burn on his leg. He lifted the left leg of his shorts and showed a darkened area, several inches long, on the lateral (outside) aspect of his left leg. R28 reported there was a lid on his cup, which he had next to him, in his wheelchair. According to R28, the lid did not seal good enough, causing the hot coffee to leak out of the side of the cup. R28 reported when the coffee spilled on him, he told staff right away, and they put stuff on to make it heal. A Progress Note for 4/18/2024 at 11:28 AM reflected, .Resident came up to writer stating that they spilled coffee from the kitchen on themselves and the floor. Writer took a look at the left thigh and measured burn. Writer cleaned burn and iced for 20 minutes. After the ice, writer applied medihoney to burn and wrapped with abd [dressing]. Writer educated the resident on safety while drinking hot beverages and also educated the kitchen staff on importance of temping foods and drinks before serving to residents . A late entry Progress Note for 4/18/2024 at 12:00 PM reflected, .Dietary staff temped coffee prior to giving to [R28], Temp in normal range, [R28] stated he placed his coffee cup on the L [left] side of his w/c [wheelchair] and as he was self propelling w/c the coffee cup tipped over. He did not alert staff and went to smoke. Offered [R28] a cup holder to his w/c. [R28] declined at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no documentation in R28's medical record or on the facility's April 2024 Coffee Temperature Log to support that the coffee temperature was checked and in a safe range prior to serving it to R28. The facility's investigation into the incident was reviewed and included an incident report for 4/18/24 at 11:17 AM, which reflected R28 came up to the nurse, stating he had spilled coffee on himself and the floor. His left thigh was assessed and noted to have blisters and a raised, red area. The immediate action taken reflected the burn was cleansed, then iced for 20 minutes. Once the ice was off, medihoney (wound and burn treatment) was applied to the wound, then covered with an ABD dressing. R28 was educated on safety precautions while drinking hot beverages, such as a lid, sitting at the table and not roaming around with drink in hand. The report reflected, .Writer also educated kitchen staff on appropriate coffee temperatures to prevent further accidents of this nature . The facility's investigation included a sign in sheet for education provided by Registered Dietitian (RD) I on 4/18/24, which reflected: -Temperatures of hot beverages must be done prior to and during meal service -Temperatures of hot beverages must be taken prior to any request by residents in between meals -Hot beverages must be below 135 degrees (Fahrenheit) prior to serving to residents -All hot beverages must have a lid on prior to serving to the resident The education was signed by seven dietary staff. The facility's investigation did not indicate a root cause analysis, nor an identification of which staff member provided the coffee to R28 on 4/18/24. During an interview on 07/12/24 at 12:32 PM, Director of Nursing (DON) B reported Dietary Aide (DA) T provided R28 with the coffee that burned him on 4/18/24 and verbalized putting three ice cubes in it. When asked why ice was placed in the coffee, DON B reported she (personally) did not document the coffee temperature at the time she looked into the incident because it was within normal limits. DON B believed the coffee temperature was in the range of low 140's (degrees Fahrenheit) and reported it may have been 144 degrees Fahrenheit. According to DON B, the temperature of the coffee that was provided to R28 was under 150 degrees Fahrenheit, and she was not concerned. DON B reported R28 sat outside to smoke two cigarettes after the coffee spilled on him. Review of the facility's staff education pertaining to hot liquids on 4/18/24 did not reflect that DA T had signed the education. On 07/10/24 at 02:20 PM, DA T reported coffee was temped after drawing it from the machine and before sending out the tray. DA T stated, The coffee temperature is usually around 160 degrees Fahrenheit from the machine and about 145 degrees Fahrenheit when delivered. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The April 2024 Coffee Temperature Log reflected a coffee temperature of 180 degrees Fahrenheit on 4/18/24 at 7:30 AM. The recheck temperature was 148 degrees Fahrenheit. At 11:30 AM on 4/18/24, the coffee temperature was 178 degrees. The recheck temperature was 147 degrees Fahrenheit. The 4:30 PM coffee temperature on 4/18/24 was 135 degrees Fahrenheit.

An undated Hot Liquid Safety policy reflected, .2. The temperatures of hot liquids will be checked in the dietary department prior to distribution to the nursing units. If the temperature is greater than 140 degrees Fahrenheit, hold the liquid in the dietary department until it reaches an appropriate temperature .

On 07/10/24 at 3:24 PM, Nursing Home Administrator (NHA) A reported the undated Hot Liquid Safety policy was the policy that was current as of 4/18/24 (when R28 sustained the burn).

Further review of the April 2024 Coffee Temperature Log reflected each initial and recheck coffee temperature exceeded 140 degrees Fahrenheit until the 4:30 PM coffee temperature on 4/18/24.

During an interview on 07/10/24 at 2:59 PM, Licensed Practical Nurse (LPN) L reported being R28's nurse at the time he sustained the coffee burn. R28 came to her and reported receiving coffee from the kitchen, which he put in the side of his wheelchair. When he went outside, the coffee spilled on his leg and burned him. By the time R28 notified her, he had already been changed. She stated he must have told a Certified Nurse Aide (CNA) or cleaned himself up before notifying her. After being notified, she put R28 in bed and placed a cold towel on the burn while gathering wound supplies, including medihoney.

During the same interview, LPN L reported she educated kitchen staff on temping of coffee. LPN L stated she knew for a fact if the coffee was temped, it would not have burned R28 the way that it did. She reported also educating R28 that it was not safe to be moving around with a hot cup of coffee (in his wheelchair). LPN L reported the burn initially appeared as the length of her cell phone, with a large blister. When she saw the burn the following week, the blister was no longer intact, and there was raw skin.

According to Mayo Clinic, .2nd-degree burn. This type of burn affects both the epidermis and the second layer of skin (dermis). It may cause swelling and red, white or splotchy skin. Blisters may develop, and pain can be severe. Deep second-degree burns can cause scarring .3rd-degree burn. This burn reaches to the fat layer beneath the skin. Burned areas may be black, brown or white. The skin may look leathery. Third-degree burns can destroy nerves, causing numbness .

(https://www.mayoclinic.org/diseases-conditions/burns/symptoms-causes/syc-20370539)

On 4/18/24, R28's burn measured 20 centimeters (cm) in length by (x) 7 cm in width. The wound photo revealed a red, raised area with intact blisters. R28's pain level was recorded as eight out of ten.

On 4/22/24, R28's burn measured 20 cm in length x 7 cm in width. The burn was staged as partial thickness (affects the top two layers of the skin). The tissue type reflected, Necrotic [dead tissue] Soft, Adherent=50%, Necrotic Hard, Firm, Adherent=50%. R28's pain level was recorded as eight out of ten. The assessment reflected the burn was Very painful.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Manor Healthcare Center	730 Kimole LN Adrian, MI 49221

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R28's burn was evaluated by the Wound Provider on 4/25/24. The assessment reflected R28 had a second-degree burn, measuring approximately 18 cm in length x approximately 6 cm in width and 0.1 cm in depth. The tissue was 75% slough (non-viable tissue that can present as yellow, tan, gray, green or brown) and 25% granulation (pink/red tissue that fills a wound when it begins to heal). On 4/29/24, R28's burn measured 20 cm in length x 5 cm in width x 0.1 cm in depth. The burn was staged as partial thickness. The tissue type reflected, Bright Pink or Red=50%, Slough Loosely Adherent=50%. R28's pain level was recorded as eight out of 10. On 5/6/24, R28's burn measured 18 cm in length x 4 cm in width x 0.1 cm in depth. The burn was staged as partial thickness. The tissue type reflected, Bright Pink or Red=100%. R28's pain level was recorded as four out of ten. R28's burn was evaluated by the Wound Provider on 5/9/24. The assessment reflected the burn was second-degree and measured 13.5 cm in length x 3.2 cm in width x 0.1 cm in depth. The tissue was 50% slough and 50% granulation. On 5/14/24, R28's burn measured 12 cm in length x 4 cm in width x 0.1 cm in depth. The burn was staged as partial thickness. The tissue type reflected, Bright Pink or Red=100%. R28's pain level was recorded as three out of ten. On 5/20/24, R28's burn measured 10 cm in length x 2.5 cm in width x 0.1 cm in depth. The burn was staged as partial thickness. The tissue type reflected, Bright Pink or Red=100%. R28's pain level was recorded as three out of ten. R28's burn was evaluated by the Wound Provider on 5/23/24. The assessment reflected the burn was second-degree and measured 8.5 cm in length x 2.3 cm in width x 0.1 cm in depth. The tissue was 50% slough and 50% granulation. Blue/green drainage was noted, with notation that it could be pseudomonas (bacteria) infection. On 6/3/24, R28's burn measured 5 cm in length x 1.7 cm in width x 0.1 cm in depth. The burn was staged as partial thickness. The tissue type reflected, Bright Pink or Red=100%. R28's pain level was recorded as zero. On 6/10/24, R28's burn measured 4 cm in length x 1.7 cm in width x 0.1 cm in depth. The burn was staged as partial thickness. The tissue type reflected, Bright Pink or Red=100%. R28's pain level was recorded as zero. R28's burn was evaluated by the Wound Provider on 6/13/24. The assessment reflected the burn was second-degree and measured 1.5 cm in length x 1 cm in width x 0.1 cm in depth. The tissue was 50% slough and 50% granulation. On 6/17/24, R28's burn measured 1.5 cm in length x 1.0 cm in width x 0.1 cm in depth. The burn was staged as partial thickness. The tissue type reflected, Bright Pink or Red=100%. R28's pain level was recorded as zero. On 6/24/24, R28's burn was recorded as healed, with intact skin. The photo showed an area of pink/red discolored skin, measuring greater than 12 cm in length. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The facility's Hot Liquid Safety policy with a revision date of 4/18/24 reflected, .2. The temperatures of hot liquids will be checked in the dietary department prior to distribution to the nursing units. If the temperature is greater than 140 degrees Fahrenheit, hold the liquid in the dietary department until it reaches an appropriate temperature of under 135 degrees .

Review of Coffee Temperature Logs for May, June and July 2024 reflected, Coffee temperature needs to be between 130-150 degrees prior to serving. Coffee that is 150 degrees or higher needs a few minutes to cool down to serve and could cause severe burns. Further review of the logs reflected numerous missed temperature recordings as well as temperatures that exceeded the facility's policy pertaining to temperature parameters, without a documented action taken.

On 7/10/24, review of the July 2024 Coffee Temperature Log reflected dinner coffee temperatures had not been recorded at all for the month.

During an interview on 07/10/24 at 4:30 PM, Dietary Manager (DM) D reported coffee was served at each meal. The coffee machine brewed coffee at a minimum temperature of 165 degrees Fahrenheit and a maximum temperature of 180 degrees Fahrenheit. Dietary staff were to take the coffee temperature and hold the coffee, as the serving temperature needed to be less than 140 degrees Fahrenheit. He reported they did not want the temperature above 140 degrees Fahrenheit because the residents could burn themselves, and it was a safety issue. DM D reported he was told R28 was given a cup of coffee and received third-degree burns on his leg.

During the same interview, DM D reported the facility also had self-serve coffee stations that were placed at the unit desks. When asked how the temperature of the self-serve coffee was monitored, DM D reported dietary staff temped the coffee when it was placed in the coffee urn. They then let it sit for 15 to 20 minutes. He reported the temperature for the coffee urns should be at least 150 degrees Fahrenheit, but he preferred it to be between 130 to 135 degrees Fahrenheit. He reported the coffee urns were insulated and would hold a temperature for many hours. When asked how he could be certain that resident's were not receiving self-serve coffee that was 150 degrees Fahrenheit, DM D stated he could not be certain. DM D reported the hot liquid policy was revised after R28's burn, and he believed anything under 140 degrees Fahrenheit was ok.

Upon review of the July 2024 Coffee Temperature Log, DM D reported most of the temperatures were out of range, and there was no documented action taken. He reported the staff should have listed that they held the coffee and taken another temperature. DM D agreed the dinner coffee temperatures were missing from the log and should have been documented.

In an interview on 07/10/24 at 4:48 PM, DM D reported Coffee Temperature Logs reflected the temperatures of the coffee served on the tray line. He stated the facility did not log the temperatures for the coffee urns before they went to the units. The coffee in the urns came straight from the brew pot at 180 degrees Fahrenheit. It then sat for 15 to 20 minutes, but a temperature was not logged.

The Immediate Jeopardy began on 4/18/24 when the facility failed to ensure R28 was provided coffee at a safe temperature, resulting in a second-degree thermal burn and increased pain. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on 7/11/24 at 1:58 PM.

The Immediate Jeopardy that began on 4/18/24 was removed on 7/11/24 when the facility took the following actions to remove the immediacy:

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NAME OF PROVIDER OR SUPPLIER: Lynwood Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 730 Kimole LN Adrian, MI 49221	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The NHA called an Ad Hoc QAPI meeting, which included the DON, Medical Director (via phone), Assistant Director of Nursing, MDS Coordinator, Registered Dietitian, and Dietary Manager. A root cause analysis was completed for the above-mentioned burn to Resident #28. 2. Dietary Manager and Registered Dietitian educated dietary staff on proper temping and serving of hot beverages. Hot beverages must be temped and logged prior to and during meal service. The temperature of hot beverages must be taken prior to any request by residents between meals. Hot beverages must be below 135 degrees Fahrenheit prior to serving to residents. 3. The DON and Social Services Director educated all staff that only dietary staff is permitted to serve hot beverages, with the exception that after hours (8 PM to 6 AM) only a nurse on duty is permitted to serve hot beverages to residents. 4. The DON educated nurses on correct process for temping and serving hot beverages. Hot beverages must be temped and logged prior to serving to residents. Hot beverages must be below 135 degrees Fahrenheit prior to serving to residents. 5. Signs were placed at both kitchen doors by the Registered Dietitian, stating only nurses can serve hot beverages to residents after hours. The Activity Director was instructed to inform residents of this at the next Resident Council Meeting. 6. The DON assessed all current residents for safe handling of hot beverages using the Hot Liquid Evaluation. Occupational Therapy was then notified for safety screening per written order for those deemed necessary. The Dietary department was notified to use spill proof cups via Dietary Communication forms for those deemed necessary. Tray tickets and care plans were updated as needed by the Registered Dietitian. 7. The Dietary Manager/designee will observe dietary staff at all meals to ensure proper temping and logging of hot beverages until assured that all dietary staff know the proper process. 8. The Dietary Manager/designee will audit temperature logs daily to ensure the process is being followed and temperatures are at approved levels for hot beverages. 9. The NHA will audit hot beverage logs weekly x 2 to ensure compliance. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 7/11/24 but noncompliance remains at a scope of widespread and a severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. 30337 DPS B: Based on observation, interview and record review, the facility failed to perform safe smoking assessments in two of three residents reviewed for smoking hazards (Resident #29 and Resident #4), resulting in the likelihood for injuries. Findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #29 (R29) On 7/09/24 at 10:09 AM, R29 was observed sitting in his room in his wheelchair with two disposable pod vaping devices placed on his over-the-bed table. R29 stated he used to smoke cigarettes, but now vapes. R29's Minimum Data Set (MDS), with assessment reference date (ARD) of 6/28/24, introduced a Brief Interview for Mental Status (BIMS, a brief cognitive screener) score of 15 (13-15 Cognitively Intact). The same MDS indicated he had the diagnoses of heart failure, diabetes, end stage renal disease requiring dialysis, lung disease, skin tears, and moisture associated skin damage. In review of R29's electronic medical record, the last smoking safety screen assessment was completed on 12/18/22. In review of R29's care plans, there were no care plans addressing vaping. Resident #4 (R4) R4's MDS with ARD of 6/19/24, revealed a BIMS score of 14 (13-15 Cognitively Intact) and had the diagnoses of traumatic brain injury, hemiplegia (complete or severe paralysis on one side of the body including face, arm and leg), seizure disorder, anxiety and depression. In review of R4's Kardex (nurse assistant care plan) dated 7/10/24, R4's smoking materials were to be kept with the nurse, and did not specify vaping materials. In review of R4's Smoking screen assessment dated [DATE], there was no mention of her vaping and indicated she was safe to smoke without supervision. The same assessment revealed continues to forget she cannot smoke indoors. Facility keeps lighter and cigarette. Certified Nurse Assistant (CNA) X was interviewed on 7/11/24 at 8:36 AM and stated R4 was not allowed to smoke except when her family was supervising due to bumming cigarettes from other residents and vaping. CNA X stated R4 had vaping materials in her possession. Director of Nursing (DON) B was interviewed on 7/11/24 at 8:48 AM and stated smoking privileges had recently changed for her. DON B stated she was not aware of R4 vaping. DON B stated smoking screen assessments were completed every six months or if there was a change. The facility provided a list of residents that smoke on 7/09/24, R29 and R4 were not included on the list. In review of the Smoking Progress policy dated 6/25/24, there was no guidance on vaping.

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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 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** 38383 Based on observation, interview and record review, the facility failed to provide a therapeutic diet to one (Resident #28) of three reviewed for nutrition. Findings include: Review of the medical record reflected R28 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included multiple sclerosis and unspecified severe protein-calorie malnutrition. The significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/23/24, reflected R28 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was coded for second or third degree burns. On 07/09/24 at 2:13 PM, R28 was observed lying in bed. He reported the food was skimpy, referring to the portion sizes he received. R28 reported his current weight was 140 pounds. On 01/01/2024, R28 weighed 167 pounds. On 07/09/2024, R28 weighed 140.2 pounds, which was a 16.05 percent weight loss. A Physician's Order with a start date of 3/18/24 and a revision date of 4/9/24 reflected R28 was to receive double protein portions at meals. On 07/10/24 at 12:03 PM, R28's lunch tray was passed to his room and consisted of a fruit cup, a carton of milk, mixed vegetables, mashed potatoes and gravy and a slice of turkey with gravy that was served over bread. R28's tray ticket reflected double protein portions were to be provided, and the order was highlighted. His meal was not served with double portions of protein. On 07/10/24 at 12:12 PM, Registered Dietitian (RD) I observed R28's lunch tray, which had not yet been consumed, and reported it did not have a double protein portion.

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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 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** 30337 Based on observation, interview, and record review, the facility failed to provide respiratory treatment in one of two residents reviewed for respiratory services (Resident #22), resulting in the likelihood of decreased quality of sleep, increased risk of stroke, heart disease, and diabetes. Findings include: Resident #22 (R22) On 7/09/24 at 10:28 AM R22 was observed sitting in his wheelchair in his room. A continuous positive airway pressure (CPAP, detects collapse of airway and increases pressure) machine was sitting on a shelf near his bed. R22 stated he did not use his CPAP machine, because it was missing a part. R22's annual Minimum Data Set (MDS) with an assessment reference date of 6/14/24, revealed he was admitted to the facility on [DATE], had a Brief Interview for Mental Status (BIMS, a short cognitive screener) score of 11 (08-12 Moderate Impairment). The same MDS revealed R22 had the diagnoses of sleep apnea, high blood pressure, Parkinsonism, anxiety, depression, dementia, and seizure disorder. Director of Nursing (DON) B was interviewed on 7/10/24 at 8:49 AM and verified R22 did not have any physician orders, past or present, for use of a CPAP machine. DON B was interviewed on 7/11/24 at 8:54 AM and stated the facility reached out to R22 power of attorney regarding the CPAP machine because the facility did not know that he had one.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46954 Based on interview and record review, the facility failed to ensure 2 out of 5 Licensed Practical Nurses had the required initial competency evaluations and annual competency evaluation, including demonstration in skills and techniques necessary to care for residents resulting in the potential for staff to lack in the necessary training to adequately meet the needs of 66 residents that currently reside at the facility. Findings Include: Record review of the facility staff personnel records demonstrated Licensed Practical Nurse (LPN) L was currently employed by the facility. The personnel record of LPN L did not demonstrate that she had completed an annual competency evaluation. During an interview on 07/12/2024 at 12:31 p.m. Director of Nursing (DON) B explained that all nursing staff receives a competency evaluation after completion of orientation and annually. She explained that the competency evaluations are completed by observation of skilled performed. DON B confirmed that LPN L personnel file did not demonstrate completion of a new hire competency and did not include an annual skills competency. DON B explained that she would attempt to locate the documents that would demonstrate clinical skills competency. Review of the facility policy entitled Competency Evaluation (provided by the facility) was absent of a date implemented and did not demonstrate a date last reviewed or revised. The Policy Explanation and Compliance Guidelines (of the above list policy) revealed #4 - Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. This surveyor was provided Licensed Practical Nurse (LPN) L post orientation skills competency which was completed 8/11/22. The facility failed to provide Licensed Practical Nurse (LPN) Ls annual skills competency evaluation for 2024 by the time of exit. 45038 Record review of the facility staff personnel records demonstrated Licensed Practical Nurse (LPN) DD was hired by the facility 2/15/2023. The personnel record of LPN DD did not demonstrate that she had completed a competency evaluation upon completion of orientation and her personnel file did not demonstrate that she had completed an annual competency evaluation. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/12/2024 at 12:31 p.m. Director of Nursing (DON) B explained that all nursing staff receives a competency evaluation after completion of orientation and annually. She explained that the competency evaluations are completed by observation of skilled performed. DON B confirmed that LPN DD personnel file did not demonstrate completion of a new hire competency and did not include an annual skills competency. DON B explained that she would attempt to locate the documents that would demonstrate clinical skills competency. Review of the facility policy entitled Competency Evaluation (provided by the facility) was absent of a date implemented and did not demonstrate a date last reviewed or revised. The Policy Explanation and Compliance Guidelines (of the above list policy) revealed #4 - Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. This surveyor was provided Licensed Practical Nurse (LPN) DD post orientation skills competency which was completed 02/16/23. The facility failed to provide Licensed Practical Nurse (LPN) DDs annual skills competency evaluation for 2024 by the time of exit.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45038 Based on observation, interview, and record review the facility failed to ensure the medication rate was less than 5% when three medication errors were observed form a total of 26 opportunities for two residents (#58, #60) of five reviewed for medication administration, resulting in a mediation error rate of 11.54%. Findings Included: Resident #58 (R58) Review of R58 medical record demonstrated that she was admitted to the facility 05/07/2024 with diagnoses that included constipation, muscle weakness, repeated falls, dysphagia (difficulty swallowing), anemia (low red blood cells) anxiety, osteoarthritis, atrial fibrillation, gastro-esophageal reflux, insomnia, osteoporosis (weak bones), vitamin D deficiency, hyperlipidemia (high fat in blood), hypoglycemia (low blood sugar), hypertension, and muscle spasms. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/2024, revealed a Brief Interview for Mental Status (BIMS) of 13 (cognitively intact) out of 15. Resident #60 (R60) Review of R60 medical record demonstrated that she was admitted to the facility 05/28/2024 with diagnoses that included cerebral infarction (stroke), muscle weakness, hemiplegia (paralysis one side of body) and hemiparesis (weakness or paralysis) of left side, anemia (low red blood cells), type 2 diabetes, kidney disease, depression, hypothyroidism (low thyroid hormone), constipation, tremors, dysphagia (difficulty swallowing), and blindness to right and left eye. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2024, revealed a Brief Interview for Mental Status (BIMS) of 14 (cognitively intact) out of 15. Section K-Swallowing/Nutritional Status of the MDS with the same ARD demonstrated a feeding tube. During medication administration observation on 07/10/2024 at 07:59 a.m. Licensed Practical Nurse (LPN) L was observed preparing R60 medication of Oxycodone 5 mg (milligrams) tablet and Gabapentin 300 mg tablet. LPN L was witnessed crushing the medication separately then placing them in separate mediation cups. At 08:10 a.m. observed LPN L stopping R60's feeding pump. Then observed her flushing R60's feeding tube with 30 ml (milliliters) of water. LPN L was then observed placing both of the above crushed medications in the same medication cup and added water to the cup. She then proceeded to place the solution in R60's feeding tube. She then was observed flushing the feeding tube with 30ml of water and restarting R60's tube feeding solution. During medication administration observation on 07/10/2024 at 08:19 a.m. Licensed Practical Nurse (LPN) L was observed preparing MiraLAX 17 grams and placed in 30 ml (milliliters) of water. She then was observed taking the MiraLAX and water into R58. R58 did not consume the MiraLAX and water solution and LPN L placed it on her over bed table and asked her to make sure she takes the solution. On 07/10/2024 at 09:07 a. m. the MiraLAX solution was observed to still be in a cup on R58's over bed table. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/10/2024 at 09:23 a.m. Director of Nursing (DON) B explained that it was facility policy and professional practice that all crushed medication that is to be given by a resident feeding tube should be administered separately. She explained that the tube would be flushed with 30ml (milliliters) of water prior to administration and flushed with 30ml of water after each medication. DON B also explained that it necessary that the nurse observe the resident take all medication unless the resident has been assessed to self-administer medication. DON B explained R58 was not assessed for self-administration. During observation on 07/10/24 at 09:31 a.m. Director of Nursing (DON) B was observed entering R58's room and it was observed that the cup of MiraLAX solution was still on the residents over bed table. DON B then observed R58 drinking the MiraLAx solution. Review of facility policy entitled Policy 5.3-General Guidelines for Medication Administration revealed Procedures number 11. Administer medication and remain with resident while medication is swallowed. Never leave a medication in a resident's room without orders to do so. Review of facility policy entitled Policy 5.3.10 Enteral Tube Medication Administration revealed Procedure number 10. Administer each medication separately, allowing to flow by gravity and flushing tube with 5ml of water after each dose.

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

22050

Based on observations, interviews, and record reviews, the facility failed to provide palatable food products effecting 66 residents, resulting in the increased likelihood for decreased resident food acceptance and nutritional decline.

Findings include:

On 07/09/24 at 11:45 A.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded:

Roasted Vegetable Lasagna - 185.5

Capri Blend Vegetables - 147.8

Garlic Toast - 140.0

Cheesecake - Room Temperature

Beverage (2% Milk) - 47.8*

(*) The 2017 FDA Model Food Code section 3-501.16 states: (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 57oC (135oF) 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 54oC (130oF) or above; P or (2) At 5 C (41 F) or less.

On 07/09/24 at 11:55 A.M., An interview was conducted with Dietary Manager D regarding the resident food tray delivery schedule. Dietary Manager D stated: We deliver food trays to the Main Dining Room, B-Hall and then A-Hall.

On 07/09/24 at 12:08 P.M., Resident food trays (18) were observed leaving the food production kitchen within a stainless steel non-insulated transport cart.

On 07/09/24 at 12:09 P.M., Resident food trays (18) were observed arriving to B-Hall within a stainless steel non-insulated transport cart.

On 07/09/24 at 12:16 P.M., Resident food trays (10) were observed leaving the food production kitchen within a stainless steel non-insulated transport cart.

On 07/09/24 at 12:17 P.M., Resident food trays (10) were observed arriving to A-Hall within a stainless steel non-insulated transport cart.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Lynwood Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 730 Kimole LN Adrian, MI 49221	

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/09/24 at 12:23 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #62: Roasted Vegetable Lasagna - 148.1 Capri Blend Vegetables - 110.7* Garlic Toast - 105.1* Cottage Cheese & Mandarin Oranges - 56.1* Cheesecake - Room Temperature Beverage (Apple Juice) - 60.6* (*) The 2017 FDA Model Food Code section 3-501.16 states: (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 57oC (135oF) 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 54oC (130oF) or above; P or (2) At 5 C (41 F) or less. On 07/09/24 at 12:31 P.M., An interview was conducted with Resident #62 regarding dietary food products. Resident #62 stated: The mashed potatoes are like eating mush. Resident #62 also stated: The eggs are nasty for Breakfast. Resident #62 additionally stated: The French toast and pancakes are usually cold. Resident #62 further stated: The scrambled eggs are overcooked and taste like rubber. On 07/10/24 at 11:42 A.M., Resident food trays (20) were observed leaving the food production kitchen within an aluminum rolling open shelve rack system. On 07/10/24 at 11:43 A.M., Resident food trays (20) were observed arriving to the Main Dining Room within an aluminum rolling open shelve rack system. On 07/10/24 at 11:58 A.M., Resident food trays (17) were observed leaving the food production kitchen within a stainless steel non-insulated transport cart. On 07/10/24 at 11:59 A.M., Resident food trays (17) were observed arriving to B-Hall within a stainless steel non-insulated transport cart. On 07/10/24 at 12:10 P.M., Resident food trays (13) were observed leaving the food production kitchen within a stainless steel non-insulated transport cart. On 07/10/24 at 12:11 P.M., Resident food trays (13) were observed arriving to A-Hall (North) within a stainless steel non-insulated transport cart. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/10/24 at 12:19 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #38: Open Face Turkey Sandwich w/Gravy - 122.1* Mashed Potatoes - 130.0* Vegetable Blend - 120.1* Dinner Roll - Room Temperature Chilled Peaches - 56.7* Beverage (Apple Juice) - 59.1* (*) The 2017 FDA Model Food Code section 3-501.16 states: (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 57oC (135oF) 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 54oC (130oF) or above; P or (2) At 5 C (41 F) or less. Note (Palatability Taste Test): The apple juice was concentrated and contained an aftertaste. The mashed potatoes were flavorful and tasteful. The open face turkey sandwich was flavorful and tender. The canned peaches were crisp and full of flavor. The dinner roll was soft and tender. On 07/10/24 at 02:20 P.M., An interview was conducted with Dietary Aide/Cook T regarding the hot beverage (coffee) dispensing and delivery procedure. Dietary Aide/Cook T stated: We temp the coffee after drawing from the machine. Dietary Aide/Cook T additionally stated: We also temp the coffee before sending out the tray. Dietary Aide/Cook T further stated: The coffee temperature is usually around 160 degrees Fahrenheit from the machine and about 145 degrees Fahrenheit when delivered. On 07/10/24 at 02:31 P.M., An interview was conducted with Resident #38 regarding dietary food products. Resident #38 stated: The chicken is always overcooked and looks like roadkill. Resident #38 further stated: Could they get rid of the sausage, gravy, and biscuits for breakfast? It's the most unappetizing meal I have ever had. On 07/11/24 at 12:30 P.M., Record review of the Policy/Procedure entitled: Maintaining a Sanitary Tray Line dated (no date) revealed under Policy: This facility prioritizes tray assembly to ensure foods are handled safely and held at proper temperatures in order to prevent the spread of bacteria that may cause foodborne illness. Record review of the Policy/Procedure entitled: Maintaining a Sanitary Tray Line dated (no date) further revealed under Compliance Guidelines: (3)(k) Periodically monitor food temperatures throughout the meal service to ensure proper hot (at or above 135 degrees Fahrenheit) or cold holding temperatures (at or below 41 degrees Fahrenheit) are maintained. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/11/24 at 12:45 P.M., Record review of the Policy/Procedure entitled: Hot Liquid Safety dated 4-18-24 revealed under Policy: Hot liquids are to be served at proper (safe and appetizing) temperatures using appropriate safety precautions. Record review of the Policy/Procedure entitled: Hot Liquid Safety dated 4-18-24 further revealed under Policy Explanation and Compliance Guidelines: (1) Hot liquids can cause scalding and burns. The degree of injury depends on the temperature, the amount of skin exposed, and the duration of exposure. Refer to the table attached to this policy for an illustration of the time required for a burn to occur at various temperatures. (2) The temperatures of hot liquids will be checked in the dietary department prior to distribution to the nursing units. If the temperature is greater than 140 degrees Fahrenheit, hold the liquid in the dietary department until it reaches an appropriate temperature of under 135 degrees. (3) All residents are assessed for their ability to handle containers and consume hot liquids. Residents with difficulties will receive appropriate supervision and use of assistive devices in order to consume hot liquids. Interventions will be individualized and noted on the resident's plan of care. Interventions include, but are not limited to: a. Wide based cups b. Cups with lids and handles c. Limit Styrofoam cups to residents with no difficulties d. Aprons e. Disallow hot liquids while lying in bed (4) Staff shall respond immediately to spills or other accidents with hot liquids to minimize the risk for burns. Follow procedures regarding incidents/accidents should anyone experience exposure to hot liquids.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to honor food preferences for one (Resident #39) of 15 reviewed. Findings include: Review of the medical record reflected R39 admitted to the facility on [DATE], with diagnoses that included dependence on renal dialysis and diabetes. The admission Minimum Data set (MDS), with an Assessment Reference Date (ARD) of 5/23/24, reflected R39 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 07/09/24 at 11:40 AM, R39 was observed seated in a wheelchair, in her room. She reported the facility needed to keep track of the food service. She reported her tray ticket reflected what she could and could not have, as well as dislikes or allergies. Per her report, they highlighted that she could not have peppers, and she had recently been served a meal that had red and green peppers all over it. The peppers aggravated her gallbladder, per her report, and she had not had peppers in 15 to [AGE] years. R39 reported paper menus were provided so the residents could make choices for meals. If she crossed off an item or requested a cheeseburger for an alternate, she did not get the dessert or the side items that would be served with the meal. During the same interview, R39 stated she went to dialysis on Tuesday's, Thursday's and Saturday's. She left facility between 06:30 AM and 6:45 AM and was told she was supposed to have a sack breakfast, something quick and easy. Per R39's report, the kitchen told her they did not provide sack breakfasts. R39 stated she would only receive a cup of coffee and did not return to the facility until around 11:00 AM. On her dialysis days, if the staff did not get her an item such as yogurt from the snack cart before she left, she did not eat anything until lunch, which was around 11:45 AM to 12:00 PM, per her report. On 07/09/24 at 12:22 PM, R39 was observed seated in her wheelchair, eating lunch in her room. She showed her meal ticket, which included that she was not to have tomato products, among other items, which were highlighted in blue. She was observed to have lasagna with tomato sauce, garlic toast and mixed vegetables. She stated she would take the belly ache later, as the tomato products upset her stomach. She stated she was going to eat the meal provided, as she was hungry and had not eaten since her yogurt at 5:45 AM. R39's Care Plan reflected she had gastroesophageal reflux disease (GERD), with interventions that included, Encourage resident to avoid .coffee (even decaffeinated) .tomato products, garlic and onions. Encourage a bland diet. A Nutrition/Dietary Progress Note for 5/30/2024 at 2:11 PM reflected, .She received information today regarding a Low Potassium, Low Phosphorus diet d/t [due to] her labs at dialysis. Her diet order has been updated . RD [Registered Dietitian] has updated her tray ticket to include the foods she needs to avoid (. tomato products .) . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/10/24 at 10:56 AM, RD I reported she gave the chef what R39 would like on her dialysis days for breakfast, including dry cereal, hard boiled eggs and yogurt. RD I stated she gave the kitchen a printout of R39's packed breakfast items to be provided before she went to dialysis. The items were to be prepared the night before R39's dialysis days. RD I reported she did not know if the kitchen was providing those items to R39.

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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** 22050 Based on observations, interviews, and record reviews, the facility failed to: (1) effectively clean and maintain food service equipment, (2) effectively date mark all potentially hazardous ready-to-eat food products, and (3) maintain the food production kitchen flooring surface effecting 66 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and resident foodborne illness. Findings include: On 07/09/24 at 09:51 A.M., An initial tour of the food service was conducted with Dietary Manager D. The following items were noted: The flooring surface was observed missing, directly beneath the Mainstreet Equipment 2-door reach-in cooler. The missing [NAME] tile surface measured approximately 3-feet-wide by 5-feet-long. Dietary Manager D indicated he would have maintenance make necessary repairs as soon as possible. The 2017 FDA Model Food Code section 6-501.11 states: PHYSICAL FACILITIES shall be maintained in good repair. The Scotsman ice machine sliding entrance door was observed loose-to-mount. Dietary Manager D indicated he would have maintenance repair the faulty entrance door as soon as possible. The Walk-In Cooler automatic door closer assembly was observed broken and sporadically functioning. Dietary Manager D stated: Parts are on order for repairs. The 2017 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. Two opened five-pound containers of GFS ([NAME] Food Service) Sour Cream were observed without an effective open or out date. The manufacturer's use-by-date was also observed to read 7-29-24. One opened five-pound container of Country Fresh Cottage Cheese was also observed without an effective open or out date. The manufacturer's use-by-date was additionally observed to read 7-22-24. The 2017 FDA Model Food Code section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The two Cobra Head beverage dispensers were observed soiled with accumulated and encrusted food residue. The Employee Breakroom Whirlpool dietary refrigerator interior was observed soiled with accumulated and encrusted food residue. The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 07/10/24 at 03:13 P.M., Record review of the Policy/Procedure entitled: Date Marking for Food Safety dated (no date) revealed under Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Record review of the Policy/Procedure entitled: Date Marking for Food Safety dated (no date) further revealed under Policy Explanation and Compliance Guidelines for Staffing: (2) The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. (3) The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. (5) The discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday). On 07/10/24 at 04:04 P.M., Record review of the Policy/Procedure entitled: Dietary Department Guidelines dated (no date) revealed under The Facility: (1) The dietary department will be maintained in a clean and sanitary manner to prevent foodborne illness. Record review of the Policy/Procedure entitled: Dietary Department Guidelines dated (no date) further revealed under Equipment: (1) All food preparation equipment, dishes, and utensils must be maintained in a clean, sanitary, and safe manner and used and repaired according to manufacturer's recommendations.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 66 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 07/09/24 at 02:00 P.M., A common area environmental tour was conducted with Director of Maintenance V and Director of Housekeeping and Laundry Services U. The following items were noted: Lobby: The drywall surface was observed (etched, scored, particulate), adjacent to the receptionist desk. The damaged wall surface measured approximately 4-feet-wide by 8-feet-long. B-Hall (North) Soiled Utility Room: The return-air-exhaust ventilation was observed non-functional. Main Dining Room: The two sets of exit door surfaces were observed (etched, scored, particulate). Director of Maintenance V indicated he would have staff repaint the door surfaces as soon as possible. Food Production Kitchen: The exterior surfaces of the two entrance doors were observed (etched, scored, particulate). Director of Maintenance V indicated he would have staff repaint the door surfaces as soon as possible. Sunroom: The two exit door surfaces were observed (etched, scored, particulate). Director of Maintenance V indicated he would have staff repaint the door surfaces as soon as possible. On 07/10/24 at 09:20 A.M., An environmental tour of sampled resident rooms was conducted with Director of Maintenance V and Director of Housekeeping and Laundry Services U. The following item was noted: 218: The restroom hand sink basin drain was observed draining very slow. Director of Maintenance V indicated he would have staff make necessary repairs as soon as possible. On 07/10/24 at 11:15 A.M., An interview was conducted with Director of Maintenance V regarding the facility maintenance work order system. Director of Maintenance V stated: We have written work order request forms for staff. Director of Maintenance V further stated: We keep the completed forms on computer for future review. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/11/24 at 01:00 P.M., Record review of the Policy/Procedure entitled: Cleaning and Disinfecting Resident's Rooms dated 10-2013 revealed under Purpose: The purpose of this procedure is to provide guidelines for cleaning and disinfecting resident's rooms. Record review of the Policy/Procedure entitled: Cleaning and Disinfecting Resident's Rooms dated 10-2013 further revealed under General Guidelines: (1) Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. (2) Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. On 07/11/24 at 01:15 P.M., Record review of the Policy/Procedure entitled: Maintenance Service dated 12-2009 revealed under Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Record review of the Policy/Procedure entitled: Maintenance Service dated 12-2009 further revealed under Policy Interpretation and Implementation: (1) The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. On 07/11/24 at 01:30 P.M., Record review of the Building Services Work Order Request Forms for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.