STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235213	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegan County Medical Care Facility	3265 122nd Ave R2 Allegan, MI 49010

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47955 Based on observation, interview, and record review the facility failed to develop a baseline care plan for 1 of 12 residents (Resident #232) reviewed for baseline care plans, resulting in the potential for unmet care needs. Findings include: Review of an Admission Record revealed Resident #232 had pertinent diagnoses which included: hemiplegia and hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting left non-dominate side and weakness. During an observation on 4/16/24 at 12:29 PM., Resident #232 was seated in his wheelchair, leaning to his left side, at a table in the dining room with his food on the table in front of him and made no attempt to initiate eating. During an observation on 4/16/24 at 12:35 PM., Certified Nurse Assistant (CNA) EE was sitting at the table in the dining room with Resident #232. CNA EE was assisting Resident #232 to eat his lunch. In an interview on 4/16/24 at 12:45 PM., CNA EE reported that Resident #232 was new to the facility, and she was not sure what assistance he required. Review of Resident #232's electronic medical record revealed no noted baseline care plan. In an interview on 4/17/24 at 12:54 PM., Registered Nurse/Nurse Educator (RN/NE) O reported that baseline care plans should be started at admission. RN/NE O reported that a baseline care plan was a resident's basic needs for care and should include things like ADLs (activities of daily living) and transfer status. In an interview on 4/17/24 at 1:04 PM., Director on Nursing (DON) B reported that a paper copy of a baseline care plan was placed into the resident's closet. DON B reported that if an admission occurred on a weekend, the baseline care plan was completed on the following Monday. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/17/24 at 1:10 PM., observed taped to the inside the closet door in Resident #232's room was a paper titled . Care Guide. This paper was observed to have two different types of transfer status information for Resident #232 which included CGA (contact guard assist) x 1 (one person) with a 2 wheeled walker plus a gait belt and a mechanical lift. During an observation on 4/17/24 at 1:29 PM., CNA F transferred Resident #232 from wheelchair into bed with a gait belt and a front wheeled walker. In an interview on 4/17/24 at 1:50 PM., CNA F confirmed that the Care Guide on the inside of Resident #232's closet door did indicate two different types of transfers. When asked how CNA F knew the transfer status of Resident #232, CNA F reported the blue card pined to the cork board next to the resident's bed that revealed a number 1 was her indication that Resident #232 was a one-person transfer. In an interview on 4/18/24 at 10:29 AM., Minimum Data Set/Registered Nurse MDS/RN R reported that the admission nurse should start a baseline care plan. MDS/RN R reported she was responsible for baseline care plans. MDS/RN R reported she was absent from work for two days following Resident #232's admission and did not complete his baseline care plan within 24-48 hours of admission. MDS/RN R reported that the paper care guide taped to the inside of Resident #232's closet door was not his baseline care plan. In an interview on 4/18/24 at 10:56 AM., DON B was asked who was responsible for baseline care plans when MDS/RN R was absent from work and DON B responded RN/NE O was able to complete care plans and so can I . In an interview on 4/18/24 at 11:17 AM., RN/NE O reported that Resident #232's baseline care plan was not completed because MDS/RN R was absent from work. RN/NE O reported that the paper care guide in Resident #232's closet was not a baseline care plan. RN/NE O reported that care plans were now a part of her responsibilities. RN/NE O stated .I didn't know it was up to me to complete baseline care plans. Review of facility policy Baseline Care Plan with an implementation date of 9/2023 reviewed by DON B and Nursing Home Administrator (NHA) A revealed .the baseline care plan will be developed within 48 hours of a resident's admission .a supervising nurse shall verify within 48 hours that a baseline care plan has been developed .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to develop and implement person centered comprehensive care plans for 2 of 12 residents (R9 and R11) reviewed for care planning, resulting in the potential of a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: R9 According to the Minimum Data Set (MDS) dated [DATE], R9 scored 14/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), had no impairments in his arms but did have impairment in his legs, and was independent in rolling left and right. Section M: Skin Conditions indicated R9 was at risk for pressure ulcers, had 1 or more unhealed pressure ulcers with 1 unstageable suspected deep tissue injury in evolution. During an observation and interview on 4/16/24 at 10:42 AM, R9 reported he was able to reposition the top portion of his body from his waist and hips side to side. Resident demonstrated moving side to side without lifting his bottom off the mattress. Certified Nursing Assistant (CNA) I stated, He (referring to R9) is red on his bottom. R9 reported he thought he had a sore on his bottom. During an observation of R9 and interview on 4/16/24 at 10:55 AM, Registered Nurse (RN) S measured a wound on right buttock at 5.5 cm x 2 cm while describing it as shearing. The skin was clear of any barrier cream. The RN stated, (R9) does not use a pad underneath his bottom because of the shearing. He scoots his bottom around. Staff monitor it and put barrier cream on it. I will chart the shearing in a skin assessment, tell the DON (Director of Nursing), and put a note in the doctor book so the PA (Physician's Assistant) will see it tomorrow. Observed the RN applying barrier cream to the shearing. The resident was not wearing underwear under a hospital gown and was lying on wrinkled sheets. During an observation on 4/17/24 at 10:34 AM, R9 was sitting in bed at 45 degrees with his knees bent while wearing a hospital gown and no underwear. His sheets were wrinkled under his bottom. He was on an air mattress set at a comfort level of 4 and alternating pressure. Review of R9's Braden (Scale for Predicting Pressure Sore Risk) dated 4/11/24 at 2:21 PM, indicated the resident was AT RISK with a score of 16.0 with slightly limited sensory perception, skin occasionally moist, chairfast, makes frequent though slight changes in body or extremity position independently, FRICTION & SHEAR as a potential problem during a move the skin probably slides to some extent against sheets .AT RISK 15-18. Review of R9's Order Summary, dated 2/6/24, revealed, Apply Desitin (barrier cream) to bilateral buttocks each shift. Every shift for skin protectant. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Order Summary dated 4/16/24 at 11:05 AM indicated staff were to monitor sheering to left buttock and apply Desitin as needed every shift. Review of R9's Care Plan on 4/17/24 and 4/18/24 01:38 PM revealed there was no person-centered treatment plan for shearing to the resident's right buttock. It was noted there was a Care Plan for the resident with foci for malnutrition related to left hell pressure sore (4/9/24), chronic pain related to pressure injuries to buttock (11/3/23), deep tissue injury to bilateral buttocks .stage 2 pressure injury to his coccyx which occurred during stay at facility .deep tissue injury to left heel which occurred at facility . (11/3/23). Review of R9's Kardex (care guide to direct Certified Nursing Assistant (CNA) person-centered care) did not indicate a treatment guide under Wound Dressing or Monitoring for the shearing on buttock area. Review of R9's Progress Note, dated 4/16/2024 at 11:00 AM, revealed, Health Status Note, Note Text: Shearing noted to left buttock. 5.5 cm (centimeter) x 2 cm. (Director of Nursing (DON) B) notified .order placed in TAR to monitor area. Skin assessment completed. Review of R9's Progress Note, dated 4/17/2024 at 2:27 PM, revealed, Health Status Note, Note Text: Special visit with (name of Medical Doctor) . Skin to buttocks examined. Very small areas of shearing to right buttock. Continue with Desitin application. Resident remains on air mattress. Skin to feet and heels also assessed. Skin intact, heels boggy to touch slowly bleachable . During an interview and record review on 4/18/24 at 11:50 AM, DON B stated, Care Plans are done by (MDS R) who does most of them, probably 95%. She attends the daily Huddles where skin integrity concerns would be discussed and then she puts the concerns in a Care Plan. She is to go to HUDDLE, take the information from them and do care plans. (MDS R) would be responsible for doing the care plan for (R9's) skin shearing. I do not know if she attended the HUDDLE when (R9's) skin was talked about. The facility does not have staff nurses get into or do care plans because they get wonky with them. They do not know the program. I guess I could train the nurses on how to do care plans in the system. If a nurse finds an issue with skin integrity, they write a progress note and tell me. The doctor and I looked at (R9's) shearing yesterday (4/17/24). It was shearing and did not look too exciting to me. During an interview and record review on 4/18/24 at 12:40 PM, RN/MDS Coordinator R stated, I attend HUDDLE up to twice a day, depending if a new nurse comes on at the afternoon shift. I was not at the facility on Monday (4/15/24) or Tuesday (4/16/24). I did not do a care plan for (R9's) skin shearing when I came back to work on Wednesday (4/17/24). I saw the wound today and did change the order from his left buttock to his right buttock. The area has just a little bit of shearing. (R9) has a history of pressure wounds. He came to the facility with one on his buttock (3/30/23) and developed another wound on his heel that has healed. Is the facility supposed to do a care plan for every little bruise and bump? Nurses do not develop Care Plans. That is left to me. If I am gone for an extended time the two other leadership nurses, (DON B and Nurse Educator) I guess could do Care Plans. 47955 Resident #11 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #11 had pertinent diagnoses which included: Schizoaffective disorder bipolar type (mental health disorder that can include hallucinations and delusions along with mood swings), restlessness and agitation and post-traumatic stress disorder (PTSD), chronic (a mental health disorder that is triggered by an event and symptoms can include flashbacks, nightmares, anxiety, and/or uncontrollable thoughts about the event). Review of a Minimum Data Set (MDS) assessment for Resident # 11, with a reference date of 3/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #11 was cognitively intact. Review of Resident #11's medical record revealed a diagnosis of post traumatic stress disorder. In an interview on 4/16/24 at 12:57 PM., Resident #11 reported she had symptoms of PTSD. Resident #11 stated there is a lady who lives here that is a trigger for me, and staff is aware . Review of Care Plan for Resident #11 revealed no noted care plan for PTSD or any triggers. Review of Social Work Note for Resident #11 dated 4/12/24 revealed .continues to acknowledge becoming triggered by another resident's personality that she perceives as negative . In an interview on 4/16/24 at 1:04 PM., Certified Nurse Assistant (CNA) F reported that Resident #11 and another resident had to be kept separated due to not getting along. In an interview on 4/17/24 at 2:30 PM., Social Worker (SW) V reported that she was responsible for care plans related to mood and behaviors. SW V reported that a resident with a diagnosis of PTSD, that does have triggers should have a care plan with the triggers listed. In an interview on 4/18/24 at 9:10 AM., Registered Nurse (RN) T reported that Resident #11 did have another resident that was a direct trigger for her. In an interview on 4/18/24 at 11:24 AM., Registered Nurse/Nurse Educator (RN/NE) O reported that Resident #11 was fixated on another resident and has had verbal altercations with this same resident. RN/NE O reported that this same resident was a trigger for Resident #11. In an interview on 4/18/24 at 11:28 AM., SW V reported that Resident #11 and another resident that she disliked have argued but this was not considered a trigger for Resident #11 and was not listed on Resident #11's care plan. SW V reported that Resident #11 did not have a specific care plan in place related to a PTSD diagnosis and any triggers. In an interview on 4/18/24 at 11:53 PM., Nursing Home Administrator (NHA) A reported that Resident #11 had become obsessed with a peer, did have a fixation on the same peer, and Resident #11 does have many different triggers. NHA A reported that there was no care plan for PTSD and triggers for Resident #11.

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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** 38905 Based on observation and interview the facility failed to properly store clean and sanitary items, maintain laundry equipment, and clean resident shared equipment. These conditions resulted in the increased risk of clean and sanitary items and equipment to become contaminated before use, increasing the risk of negative outcomes for the resident population. Findings include: During a tour of the facility, with Maintenance Director FF, starting at 9:27 AM on 4/17/24, the following observations were made: The Hillcrest North linen closet found an accumulation of dust and debris located underneath the bottom open wire racks, leaving clean linens open and exposed to possible contamination from cleaning. The clean utility room in [NAME] was found with a cardboard covering on shelves containing clean and sanitary personal hygiene products. An observation of the private bathroom in room [ROOM NUMBER] found a cloth chair stored between the shower and the commode. The Hillcrest South spa was found with cleaning products and personal hygiene products stored commingled in the floor cabinet. The Hillcrest South linen closet was found with an accumulation of dust and debris under the bottom rack and no bottom barrier to protect clean linens from contamination due to cleaning. The Oxygen supply room was found with a dozen packs of oxygen tubing stored underneath the wastewater line of the sink. An observation of the beauty shop found hygiene products and hair care items stored underneath the wastewater line of the sink. Observation of the laundry room found three linen carts used to process and store linens, When asked if these carts would be used for clean linen, Laundry Aide GG, stated yes. The carts were found to be ripped, tattered, and torn with numerous openings in each cart. One of the carts false bottom had been replaced with a piece of plywood that is not smooth and easily cleanable. 46999 Review of facility policy, Routine and Transmission Based Cleaning and Disinfecting, with a reference date of 3/2023, revealed a statement This facility will ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment .to prevent the development of and transmission of infections . consistent surface cleaning and disinfection will be conducted with a detailed focus on high touch areas. (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 observation on 04/18/24 at 10:18 am, Resident #26 sat with Activity Assistant (AA) DD at a dining table in the memory care unit common area and colored a picture using colored pencils. Approximately 50 colored pencils were available in a plastic storage container. AA DD reported the pencils were for community use. AA DD reported during the pandemic, resident's had their own coloring supplies in effort to avoid cross contamination. During an observation on 4/18/24 at 10:19am, Resident #26 dropped a maroon-colored pencil on the floor. The floor under the table was soiled with food particles from breakfast. AA DD retrieved the pencil from the floor and handed it back to Resident #26 without cleaning it. Resident #26 continuing coloring, then selected a new colored pencil a few minutes later and the maroon pencil was returned to the shared box of supplies. In an interview on 04/18/24 at 10:22 AM, (AA) DD reported there was no set schedule for cleaning activity supplies, and items were just cleaned as needed. AA DD added unless someone is sick, we clean on demand. In an interview on 4/18/24 at 9:41am, Infection Preventionist/Director of Nursing (DON) B reported the Activity Director (AD) C had a schedule for cleaning of shared activity supplies, including the sensory supplies that were available for all residents in the day room and other common areas. In an interview 04/18/24 01:40 PM, AD C reported the activity supplies in the common areas should be cleaned by the responsible staff after each use. AD C reported the supplies were easily accessible by all residents and could be touched by several residents. When told the activity supplies in the day room appeared soiled, AD C stated I'm not surprised. I should work on a cleaning schedule to make sure items are cleaned. AD C reported he developed policies for cleaning of bingo supplies, the supplies used for balloon toss, and for personal fidget items, but had not developed a schedule for cleaning activity supplies that were available to all residents in the common areas of the facility. AD C reported the facility also did not have a cleaning procedure for a companion robot cat and he planned to determine the best method for cleaning it. AD C reported the device had been in use for several weeks, had not been cleaned, and was kept in the common area where multiple residents could access it. During an observation on 4/18/24 at 10:17am, a companion robotic cat (an interactive sensory stimulation tool designed to encourage residents to touch and hold it as they would a cat) sat on the dining table in the common area of the memory care unit. The robotic cat was covered with faux fur. During an observation on 04/18/24 at 12:13 PM, sensory stimulation items including a tackle box with simulated fishing supplies, and a toggle switch board were stored on an open shelf in the day room. The shelf was easily accessible and stood approximately 3' high. The sensory toggle switch board was soiled with 3 spots of dried brown liquid on the top of the device, adjacent to the toggle switches. The outside of the tackle box was soiled with a 3 area of dried brown liquid. The inside of the lid was soiled with more than 30 white flakes that appeared to be dried skin. A dried white substance was also present on the lid. The upper tray of the box was soiled with dried brown liquid, and sticky residue was present on the handle of a plastic clamp in the bottom of the box. In an interview on 04/18/24 at 12:39 PM Housekeeper BB reported she cleaned the resident day room, including the activity supplies in the room (wiped them down) on this date, and the expectation was that any staff member that distributed the activity supplies would clean them after use. (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 observation on 4/18/24 at 1:31pm a handheld toggle switch board that sat on the open shelf in the day room, was noted to be soiled with 3 spots of dried brown liquid. The spots were near the toggle switches and along the edge where a user would place their hand to hold the device. During an observation on 04/18/24 at 01:33 PM the soiled tackle box was opened and sat on the table in the day room, the dried brown liquid remained on end of box, dusty debris remained on the inside of the lid, along with the white dried liquid also on the inside of the box. In an interview on 4/18/24 at 1:54pm, DON B confirmed the toggle switch board and tackle box were soiled and should have been cleaned after each use in order to maintain sanitary conditions and reduce the potential for cross-contamination.