STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER: Lourdes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2300 Watkins Lake Rd Waterford, MI 48328	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on interview and record review the facility failed to ensure non-pharmacological interventions were utilized prior to the use of an as needed anti-anxiety medication for one resident (R23) of five residents reviewed for unnecessary medications, resulting in the potential for inappropriate use of an anti-anxiety medication. Findings include: On 7/22/24 at 10:22 AM, a review of R23's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: dementia, major depressive disorder and adjustment disorder. R23's most recent completed Minimum Data Set assessment dated [DATE] revealed R23 had mild cognitive impairment and was independent with most activities of daily living. A review of R23's orders revealed an order dated 7/2/24 for Xanax (anti-anxiety medication) 0.25 milligrams every 12 hours as needed for 14 days. R23's medication administration record (MAR) revealed a dose of the medication was given on 7/10/24 at 1:05 PM. A Behavior Note dated 7/10/24 at 8:03 PM entered into the record by Nurse 'D' was reviewed and read, . Resident was given a prn (as needed) xanax for increased agitation r/t (related to) room mates <sic> TV volume being too loud .Resident walking out into the hallways pacing. Resident Son arrived a <sic> hour later to transport resident to an appointment, Resident smiling and calm, no further behaviors noted after she returned from appointment . The note did not indicate any non-pharmacological interventions attempted prior to the administration of as needed Xanax. Further review of the MAR, assessments, Kardex, and care plans was conducted and there was no evidence of any resident specific-targeted behaviors or non-pharmacological interventions to attempt prior to administration of the as needed anti-anxiety medication. On 7/23/24 at 10:00 AM, an interview was conducted with Nurse 'D'. They were asked if they recalled administering R23 the medication on 7/10/24. Nurse 'D' reviewed their progress note and said they did. They were asked if they attempted any non-pharmacological interventions prior to the administration of the medication and they said they did. They were asked why it wasn't documented and said they should have put it in their progress note. They were then asked where they could find resident specific targeted behaviors for R23 and said it should be in the care plan. On 7/23/24 at 12:41 PM, an interview with the facility's Director of Nursing was conducted and they reported resident specific targeted behaviors should be documented in the care plan and prior to administering as needed anti-anxiety medications and non-pharmacological interventions should be attempted and documented in a progress note prior to the administration. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided policy titled, Behavior Management was conducted and read, 9. Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 34208 Based on interview and record review, the facility failed to obtain labs in a timely matter for one resident, (R81) of one resident reviewed for labs, resulting in the potential for delayed treatment. Findings include: On 7/23/24 at 11:24 AM, a review of R81's physician's orders was conducted and revealed the following: An order dated 5/2/24 for a urinalysis and urine culture and sensitivity lab with a discontinuation date of 5/15/24. An order dated 5/8/24 for a urinalysis and urine culture and sensitivity lab with a discontinuation date of 5/15/24. An order dated 5/13/24 for a urinalysis and urine culture and sensitivity lab with a completed date of 5/14/24. A review of R81's lab results in the record did not reveal any results for the lab ordered 5/2/24. A review of R81's progress notes was conducted and did not reveal any information regarding the lab ordered on 5/2/24. Continued review of the notes revealed the following: A note dated 5/8/24 at 3:54 PM that read, .Resident complained of burning on urination and urinary frequency . NP (Nurse Practitioner) .notified. Order received to dip urine. Urine specimen collected and noted to be cloudy. Dip was positive .NP ordered it to be sent for microscopic UAand <sic> urine C and S (urinalysis and culture and sensitivity) Specimen awaiting for pick up. A note dated 5/13/24 at 4:38 PM that read, .Order completed for UA &CNS (urinalysis and culture and sensitivity). Pending lab pick up, placed in fridge. A late entry note for 5/17/24 entered into the record on 5/20/24 that read, .Lab stated that prior UA obtained was not able to be tested . New urine obtained via clean catch and sent with lab technician for C&S. NP aware urine still pending . On 7/23/24 at 12:41 PM, an interview was conducted with the facility's Director of Nursing was conducted regarding R81's labs. They were asked about the order dated 5/2/24 and said it appeared it was not done. They were then asked about the lab order dated 5/8/24 but not documented as being done until 5/13/24 and they said they would look into the delay. A review of a facility provided policy titled, Laboratory Process was reviewed but did not address the staff's responsibility for obtaining and sending out urine specimens.

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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. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen and failed to ensure dishware was properly sanitized. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 7/22/24 between 11:00 AM-11:30 AM, during a kitchen tour with Director of Dining E, the following was observed: In the dry storage room, there was a buildup of dust, trash and food debris on the floor under the racks. In addition, there was a box of bananas, with numerous bananas that were completely black, and several that were split open. There were fruit flies observed swarming inside the box. When queried, Director of Dining E stated, We usually freeze them for banana bread when they get ripe, but those need to get tossed. According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: .4. (D) Eliminating harborage conditions. The ventilation cover located above the ice machine was observed to be coated with dust. According to the 2017 FDA Food Code section 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition, (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. The flooring in between the ice machine and the wall was observed to be soiled with a black mold-like substance. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. There was water leaking from the pipes underneath the dish machine. There was standing water on the floor, and there was a buildup of a black, slimy substance on the floor. In addition, the holes in the floor drain cover in front of the dish machine, were almost completely clogged with black sludge. According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair, A plumbing system shall be: (A) Repaired according to law; P and(B) Maintained in good repair. On 7/22/24 at 11:50 AM, in the split kitchenette, there was an unlabeled spray bottle of an unknown chemical. Director of Dining E stated she did not know what was in the bottle, but confirmed it should have been labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 7-102.11 Common Name, Working containers used for storing POISONOUS OR TOXIC MATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material. On 7/22/24 at 11:55 AM, the high temperature dish machine located in the 300 kitchen was tested with Director of Dining E. The dish machine was run approximately 4 times, and after reading the digital display for the wash and rinse temperatures, Director of Dining E stated that the water temperatures were not getting hot enough. When queried as to what temperature the wash and rinse cycles should be, Director of Dining E stated the wash cycle should be 140 (degrees Fahrenheit) and the rinse temperature should be 180. Director of Dining E stated, My staff have been telling me they couldn't get this machine to work right. Now I know what they mean. I've never had a problem with it. This surveyor then tested the temperature of the dish machine with a Thermoworks plate simulating dishwasher tester, the the surface temperature was noted to be 137 degrees Fahrenheit. Review of the 300 kitchen Dish Machine Temperature Log for July, noted documented wash temperatures that ranged from 112 degrees Fahrenheit to 128 degrees Fahrenheit (the log noted wash temperature should be 150 degrees Fahrenheit). In addition, there were several documented rinse temperatures that ranged from 125 degrees Fahrenheit to 135 degrees Fahrenheit (the log noted rinse temperature should be 180 degrees Fahrenheit). Director of Dining E was unable to provide an explanation for why staff continued to use the dish machine when it was not properly sanitizing. According to the 2017 FDA Food Code section 4-703.11 Hot Water and Chemical, After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: .(B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under SS 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71 C (160 F) as measured by an irreversible registering temperature indicator; P.

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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** 32568 Based on observation, interview, and record review, the facility failed to properly utilize personal protective equipment (PPE) for three (R20, R53, and R169) of three residents reviewed for transmission based precautions (TBP). Findings include: On 7/22/24 at 9:08 AM, staff were observed in R169's room wearing a gown and gloves. Signage was observed on the door that indicated R169 was on contact precautions (TBP intended to prevent transmission of infectious agents via contact with the person or their environment). The signage indicated a gown and gloves were to be donned when entering R169's room. Coat hooks were observed inside of R169's room labeled CNA (Certified Nursing Assistant) and Nurse. On 7/22/24 at 3:02 PM, R169 was observed sleeping in bed. Reusable gowns were observed hanging on hooks inside of the room. A family member was observed seated in a chair in the room without any PPE on. On 7/22/24 at 3:15 PM, an interview was conducted with Registered Nurse (RN) 'A'. When queried about why R169 was on contact precautions, RN 'A' stated, She is on contact, but isn't really and reported R169 was infected with Clostridium Difficile (C-Diff, a highly contagious infection of the large intestine that causes diarrhea) but did not currently have any symptoms. RN 'A' explained PPE was still required when entering R169's room. When queried about the gowns hung in R169's room, RN 'A' reported gowns were required when in R169's room and the staff reused the same gown unless soiled. RN 'A' reported the only time staff had to change a gown with each contact was for the residents who were on TBP for COVID-19 (Coronavirus Disease 2019). When queried about whether R169's visitor was required to wear PPE when in R169's room and making contact with her environment, RN 'A' stated, Her husband doesn't have any contact with her. RN 'A' further explained she had educated R169's visitor to wear PPE in the room because he wouldn't be able to handle it. A review of R169's clinical record revealed R169 was admitted into the facility on [DATE] with diagnoses that included: C-Diff. A review of R169's Physician's Orders revealed orders for antibiotic treatment that was not yet completed (stop date of 7/31/24) and an active order for TBP (contact precautions) that were started upon admission. On 7/23/24 at 8:38 AM, an interview was conducted with the Director of Nursing (DON) and Infection Control Preventionist (ICP) 'B'. When queried about the protocol for PPE when a residents was on contact precautions, the DON asked ICP 'B' to get the facility's policy. When queried about whether family members were required to follow TBP, the DON reported they needed to follow the plan of care and they were supposed to be educated. However, they could not force the visitors to wear PPE. When queried about whether gowns were to be reused for residents in contact precautions for C-Diff or droplet precautions for COVID-19, the DON reported a new gown should be worn for each contact with the resident and disposed after use, before exiting the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility policy titled, Isolation Precautions, dated January 2024, revealed, in part, the following: . Contact precautions are measures that are intended to prevent transmission of infectious agents, including epidemiologically important microoganisms, which was spread by direct or indirect contact with the resident or the resident's environment .Facility staff will use Transmission-Based Precautions, in addition to standard precautions, for resident who was known or suspected to be infected or colonized with infectious agents which require, as determined by the CDC (Centers for Disease Control), additional controls to effectively prevent transmission .The facility will use standard approaches, as defined by the CDC, for transmission-based precautions: .contact .droplet precautions. The category of transmission-based precautions will determine the type of PPE to be used .Clostridium Difficile .Contact .COVID-19 .Droplet .Full PPE . A review of a facility policy titled, Infection Control Program, revised May 2024, revealed, in part, the following: .Visitors coming to visit a resident who is on transmission-based precautions .will be informed by the facility of the potential risk of visiting and precautions necessary when visiting the resident . 47283 R20 On 7/22/24 at approximately 11: 45 AM an initial observation was completed. R20's room door was closed. R20's room was a private room. The room door had a yellow PPE bag with supplies that included reusable gown, gloves, N95 masks (a mask designed to achieve a very close facial fit and very efficient filtration of airborne particles), goggles. The door had signage that read droplet precautions. A follow-up observation was completed at approximately 12:30 PM the same day. During this observation RN A, who assigned to care for R20 was standing outside R20's doorway speaking with the family member who was in R20's room. RN A reported to the surveyor that R20 tested positive for Covid-19 and they were started on Paxlovid (prescription treatment for COVID-19) on 7/19/24. During this observation an interview was completed with R20's family member. The Family member reported that R20 tested positive for Covid and they were getting treatment. The entry way to the room had hooks on the right side of the wall labeled as Nurses, CNAs. There were two used reusable gowns hanging on the wall. A 2nd follow-up observation was completed later that day at approximately 3:55 PM. R20's room had 2 used re-usable gowns hanging on the wall hooks. Review of R20's clinical record revealed that R20 was long-term resident of the facility admitted on [DATE]. R20's progress note and care plan revealed that they tested positive for COVID-19 on 7/19/24 and they were placed under droplet precautions. An interview with the RN A was completed on 7/21/24 at approximately at 4:15 PM. RN A was queried about their PPE process for droplet precautions, in reference to R20. They reported that staff were supposed to use clean re-useable gown in addition to other PPE and bag the reusable gown and discard other PPE supplies appropriately after use. RN A was queried on why R20's room had 2 used reusable gowns hanging on the wall hook and they reported that that was probably from three days ago when R20 was enhanced barrier precautions prior to testing positive for Covid. RN A added that staff should have bagged it and they were going to take care of it. R53 (continued on next page)

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/24 at approximately 11: 35 AM an initial observation was completed. R53's room door was closed. R53's room was a private room. The room door has a yellow PPE bag with supplies that included reusable gown, gloves, N95 masks (a mask designed to achieve a very close facial fit and very efficient filtration of airborne particles), goggles. The door had signage that read droplet precautions. Upon opening door, the surveyor observed from the doorway two used re-usable gowns hanging on the wall hooks on the right side of the wall that were labeled nurses, CNAs. Later that day at approximately 3:45 PM a follow up observation was completed from the doorway. Upon opening the door R53 was observed sitting up in their wheelchair. There were 2 used re-usable gowns hanging on the wall hook. Review of R53's clinical record revealed that R53 tested positive for COVID-19 on 7/19/24 and they were placed on droplet precautions. Resident were receiving hospice services. An interview was completed with the LPN C on 7/22/24 at approximately 4PM. LPN C was assigned to care for R53 during that shift. LPN C was queried about the facility PPE process for droplet precautions and queried about the used gowns that were hanging on the wall hooks in R53's room. LPN C reported that they were used gowns. They had assigned hooks for the nurses and CNAs. After they used the gown they removed and placed on the wall hook for reuse. If the reusable gown were soiled they had changed to a new gown, if not the used gowns were placed in plastic bags at the end of the shift.