STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235285	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Lansing	731 Starkweather Dr Lansing, MI 48917

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to revise care plans for three (Resident #34, #57, and #62) of 16 reviewed. Findings include: Resident #34 (R34) Review of the medical record revealed R34 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included Parkinson's Disease and unsteadiness on feet. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/9/24 revealed R34 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the fall care plan initiated on 2/1/24 revealed the following interventions: - Place walker within reach of bed on the left side - Resident often chooses to use four wheeled walker despite therapy recommendations and education of risks. Therapy gave resident standard front wheeled walker - Encourage resident to slow down with his motorized wheelchair - Dycem to wheelchair Review of the Activities of Daily Living (ADL) care plan initiated 2/1/24 revealed the following: - Ambulation: 1 person assist with 2ww [two wheeled walker]. Often chooses to ambulate independently. Please encourage [R34] to allow someone to be with him while using walker and not use 4ww [four wheeled walker] (as it is not safe at this time). - Transfers: 1 person assist with 2ww - Uses a motorized wheelchair for locomotion throughout the facility (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 11:49 AM and 10/02/24 at 8:13 AM, R34 was observed in their bed. R34's standard (non-motorized) wheelchair was against the wall on the left side of the bed. There was no dycem in the wheelchair. R34's four wheeled walker was against the wall on the other side of the wheelchair. The walker was not in reach of the bed per the care plan. R34 did not have a two wheeled walker in his room per the care plan. On 10/02/24 at 8:50 AM, R34 was observed self-propelling his standard wheelchair throughout the hallway. In an interview on 10/02/24 at 11:12 AM, Director of Nursing (DON) B reported R34 was only able to safely use their motorized wheelchair outside, therefore the motorized wheelchair was stored in the lobby of the facility. DON B reported R34 was not safe to use the four wheeled walker but was unsure of where R34's two wheeled walker was located. DON B reported the dycem to wheelchair was for R34's motorized wheelchair. DON B agreed R34's care plans needed to be updated. Review of the Power-Mobility Indoor Driving assessment dated [DATE] revealed R34 had poor safety awareness with power w/c [wheelchair] indoors, at risk of causing harm to himself or others. Recommend manual w/c indoors, able to utilize power chair for outdoor mobility with supervision. On 10/02/24 at 5:00 PM, R34 was observed in the parking lot, driving their motorized wheelchair without staff supervision. 45135 Resident #62 (R62) Review of the medical record reflected R62 was admitted to the facility on [DATE]. Diagnoses of other fractures of lower end of right radius, multiple fractures of ribs, right side, bi-polar, and muscle weakness. Record review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated severe cognition impairment. Record review of a physician's orders dated 08/27/2020, revealed an order for Resident #62 to use a wheelchair. The order also clarified that physical therapy recommended skilled physical therapy (PT) 5-6 days a week for a duration of 8 weeks to provide therapeutic exercise, therapeutic activities, neuromuscular re-education, and wheelchair training in 1:1/group/concurrent settings as indicated due to unsteady gait. Record review of the care plan Intervention dated 08/09/24 revealed R62 used a walker for ambulation/transfer. R62 had an Activities of Daily Living (ADL) self-care performance deficit related to cognitive impairment, delirium, dementia, generalized weakness, history of falls, poor balance, psychoactive drug use, Bipolar, difficultly walking Date Initiated: 08/09/2024 Revision on: 08/13/2024. During an Observation of 10/02/24 at 08:25 AM, R62 was sitting at the table in the common area eating his breakfast while sitting in his wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 10/02/24 at 4:09 PM, R62 was sitting on his bed watching [NAME] on TV with a Certified Nursing Assistant (CNA) T sitting in a chair close to his bed watching TV with him. CNA T stated R62 needed one on one supervision at all times due to the right sided non-weight bearing from his fall on 08/20/2024. Observation of a large wheelchair sitting in his room, and no walker within site. During an interview and observation on 10/03/24 at 08:21 AM, R62 was in the physical therapy department using the sci-fit bike (a special exercise bike). Physical Therapy Assistant (PTA) K stated after his fall on 08/20/24, R62 is none weight bearing on the right side, and required a one on one CNA supervision at all times due to safety. PTA K also stated they stopped using the walker after his fall on 08/20/24. PTA K added that it is easier and safer for him to use wheelchair. During an interview on 10/03/24 at 08:26 AM, Physical Therapy Manager U stated they took away the walker when he fractured his right arm and ribs, and start using the wheelchair due to non-weight bearing on the right side. Physical Therapy Manager U also stated they updated R62 orders and recommendations within their department then it went to the unit manager M to update the care plan. During an interview and observation on 10/03/24 at 08:31 AM, Unit Manager M stated R62 used the walker on 08/20/24 when he fell . R62 was sent out to the hospital and due to multiple fractures, R62 was non-weight bearing on the right side. Unit Manager M also stated that when R62 came back to the facility, he was more unsteady. Unit Manager M also stated R62 was using the wheelchair for his safety as well as the one-on-one CNA supervision for safety reasons. During this same observation, Unit Manager M looked up R62's care plan, and stated that it did not have the use of the wheelchair on the care plan. Unit Manager M stated she removed the walker and added wheelchair to R62's care plan. 49103 Resident #R57 (R57) On 10/1/24 at 9:22 AM during observation and interview R57 was alert and able to participate in an interview. R57 was up independently in the room with a steady gait. R57 talked about interests such as going to the store which he does independently. Review of the electronic medical record (EMR) revealed R57 was admitted to the facility 4/17/24 with pertinent diagnoses of Memory Deficit following other Cerebral Vascular Disease (a disease which includes a variety of medical conditions that affect the blood vessels of the brain and cerebral circulation) and Schizoaffective Disorder, Bipolar type (a mental health condition that is marked by a mix of symptoms such as hallucinations, delusions, and mood disorder). According to a Minimum Data Set (MDS) report dated 7/27/24 R57 had a Brief Interview for Mental Status score of 09 indicating moderate cognitive impairment. R57 is listed as his own representative. Further review of the EMR revealed a note entered 9/16/24 by Physician Assistant (PA) AA which stated in part that R57 had an episode of . acute alcohol intoxication again. after drinking a bottle of Tequila. The note further said that R57 (at the time of the visit) did not . appear altered. but had . some upset stomach and nausea. PA AA discussed with R57 the importance of avoiding drinking and potential medication interactions with alcohol. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 3:33 PM during interview with the Director of Nursing (DON) B the care plan was reviewed. It was noted that there was no entry in the care plan concerning R57's risk related to alcohol consumption. The DON confirmed this and said there should be a care plan item in place addressing the problem. On 10/2/24 at 3:53 PM Social Worker (SW) C submitted a care plan item which addresses R57's history of substance abuse disorder. SW C explained this was previously a part of the main care plan and when the care plan was updated it did not come through but as of the day of survey had been added. The care plan states in part, Resident will remain free of substance abuse (unless physician prescribed) and will not have evidence of a relapse through the next review. Date initiated 10/2/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 Based on observation, interview and record review, the facility failed to prevent an elopement and respond timely to a door alarm for one (Resident #33) of one reviewed. Findings include: Review of the medical record reflected Resident #33 (R33) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included unspecified dementia, unsteadiness on feet and disorientation. The modified admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/9/24, reflected R33 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R33 was coded for wandering one to three days during the assessment look-back period that placed them at significant risk of getting to a potentially dangerous place, such as stairs or outside of the facility. On 10/01/24 at 10:10 AM, R33 was observed ambulating in the hallway, using a rolling walker. A wanderguard bracelet was observed on their left ankle. On 10/03/24 at 7:29 AM, R33 was observed lying in bed. A wanderguard bracelet was observed on their left ankle. R33's Care Plan, which was initiated on 5/3/24 and revised on 7/16/24, reflected they were at risk for elopement related to unsafe wandering and attempts of exiting a door at the end of a hall. An intervention, which was initiated on 5/3/24, reflected R33 wore a wanderguard device. An Incident Report for 6/10/24 at 11:40 PM reflected the nurse was notified by the Certified Nurse Aide (CNA) that R33 was not in their room and not accounted for in the facility. Staff began looking for R33 after discovering they were missing. A facility timeline reflected the following: -At 11:35 PM, R33 exited their room on D hall. -At 11:36 PM, R33 walked around the nurse's station and down B hall. -At 11:37:10 PM, the B hall door alarm went off, lights at the nurse's station began flashing and R33 exited the door. -At 11:37:26 PM, Licensed Practical Nurse (LPN) G walked to the nurse's station to check for the source of the alarm. CNA I met LPN G at the nurse's station and had a brief conversation. -At 11:37:50 PM, LPN G checked the B hall door with CNA I. -At 11:38 PM, the alarm was turned off by CNA I, but the flashing light alarm continued. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 11:38:40 PM, LPN G notified the D hall CNA to check that residents were in the building. -At 11:39 PM, CNA H exited C hall. -At 11:40 PM, R33's room was checked, and it was noted they were not in bed. Staff ran down the hall to alert other staff. -At 11:41 PM, LPN G exited the facility to find R33. -At 11:42 PM, the remainder of the staff looked for R33 in the building. A CNA exited the facility to check the perimeter. -At 11:51 PM, the nurse and R33 entered the facility through the front door. A statement by CNA H reflected they last saw R33 when giving them water around 11:20 PM. R33 was in bed, sleeping, at that time. It was not long after when CNA H saw lights at the nurse's station blinking. CNA H went to check the panel, and it showed the alarm was from B hall. CNA H went to B hall immediately and met two other staff. A code yellow was called. CNA H went to R33's room and could not locate them. Staff went outside to look, and a nurse got in their car. During a phone interview on 10/03/24 at 8:02 AM, LPN G reported that when the door alarm went off, she immediately went to the panel at the nurse's station and saw that it was for the B hall exit door. LPN G reported she ran to the door and did not see anyone. A code yellow was called for everyone to check if any residents were gone. A CNA said R33 wasn't there. Staff checked the entire building and perimeter and could not locate R33. LPN G reported she got in her car, drove around and located R33 walking. R33 was on a road adjacent to the facility. LPN G reported R33 must have gone through the bushes on the facility's property to get to where they were, otherwise she would have seen R33 on the facility's road when she went to the exit door. According to a written statement by LPN G, the B hall exit door was open when staff approached it in response to the alarm. During an interview with former Nursing Home Administrator (NHA) R on 10/03/24 at 10:11 AM, she confirmed that R33 had a wanderguard at the time of the elopement, but the B hall exit door did not have a wanderguard alarm on it. She reported R33 was in the parking lot of a hotel behind the facility when located by staff. Former NHA R stated she did not know how long R33 was outside for, but her understanding was that it was not long. During an interview on 10/03/24 at 10:24 AM, Director of Nursing (DON) B stated staff checked the nurse's station first, rather than the door. She reported when an alarm sounded, you could hear where it was coming from without checking the panel first. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: -Residents who were at risk for elopement had elopement assessments completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An extra alarm was placed on the B hall door to alert staff to the location of a door alarm more quickly. All end exit hall doors have this alarm. -Staff were educated on the Elopement Prevention and Response policy and code yellow process prior to working their next shift. -An ad hoq QAPI meeting was completed on 6/11/24. -Code yellow drills were conducted weekly on each shift for four weeks, then monthly thereafter on different shifts. The facility was able to demonstrate monitoring of the corrective action and maintained compliance. 32064 An observation on 10/03/24 at 11:47 AM with Maintenance Director (MD) S revealed all hallway exit doors had two alarms. The first alarm was a 15 second delayed egress. The alarm sounded when the door bar was pushed. The alarm continued to sound for 15 seconds before the door could be opened. Once the door was opened, the alarm continued to sound and a second, louder, alarm sounded. Overhead lights flashed at the nurses' station and the monitor at the nurses' station indicated what door alarmed. In an interview on 10/03/24 at 12:06 PM, Director of Nursing (DON) B reported the second, louder alarms were the new alarms installed on the doors after R33 eloped from the facility.

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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** 38383 Based on observation, interview and record review, the facility failed to ensure monitoring of an antipsychotic medication according to provider recommendations for one (Resident #58) of five reviewed. Findings include: Review of the medical record reflected Resident #58 (R58) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included mood disorder due to known physiological condition, major depressive disorder and anxiety disorder. The modified quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/24/24, reflected R58 had short-term and long-term memory impairments. On 10/01/24 at 1:34 PM, R58 was observed seated on their bed. R58's medical record reflected an order for 25 milligrams (mg) of Quetiapine Fumarate (Seroquel/antipsychotic medication) to be given in the morning for mood disorder due to known physiological condition. An additional order reflected R58 was to receive 100 mg of Quetiapine Fumarate at bedtime for mood disorder due to known physiological condition. A Psychiatric Services Progress Note for 5/2/24 reflected the risks of Seroquel included but were not limited to hyperglycemia (high blood sugar) and postural hypotension (orthostatic hypotension/low blood pressure when standing, after sitting or lying down). A Psychiatric Services Progress Note for 8/29/24 reflected recommendations to increase R58's Seroquel dose to 50 mg at bedtime for one week, then 75 mg at bedtime for one week, then 100 mg at bedtime, ongoing, for mood instability and impaired sleep. The note reflected Seroquel risks included but were not limited to hyperglycemia and postural hypotension. The note further reflected orthostatic blood pressures should be taken every shift when an antipsychotic medication was started or when the dose was increased. According to the note, hemoglobin A1C (blood test that reflects the average blood sugar level for the past two to three months) and a lipid profile (blood test to measure the amount of cholesterol and triglycerides (a type of fat) in the blood) should have been monitored every six months. An electrocardiogram (EKG/test that measures electrical activity of the heart) was also recommended, if not recently obtained. R58's medical record did not reflect that a lipid profile, hemoglobin A1C or an EKG had been performed. R58's medical record did not reflect that orthostatic blood pressures were being monitored. R58's medical record did not reflect documentation that their Physician declined the recommended tests. On 10/02/24 at 10:32 AM, an email was sent to Nursing Home Administrator (NHA) A for R58's EKG results, hemoglobin A1C results and lipid profile results, if available. Orthostatic blood pressures since the date of admission were also requested. The items were not received prior to the survey exit on 10/3/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/24 at 10:36 AM, Director of Nursing (DON) B reported orthostatic blood pressures should have been monitored monthly for residents that were receiving antipsychotic medications. DON B reported there was usually a physician's order for orthostatic blood pressures. She stated she did not see an order for orthostatic blood pressures for R58 since May 2024. DON B reported she did not locate hemoglobin A1C, lipid profile or EKG results for R58. DON B stated when Psychiatric Services providers recommended tests, the facility would typically order them, as the facility's Physician and Nurse Practitioner usually followed Psychiatric Services recommendations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to ensure their medication error rate was below 5% when two medication errors were observed from a total of 25 opportunities for two residents (Resident #22 and Resident #36) of four reviewed resulting in a medication error rate of 8%. Findings include: Resident #36 (R36) Review of the medical record revealed R36 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included urosepsis (urinary tract infection that leads to sepsis). Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/26/24 revealed R36 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 10/1/24 revealed ertapenem sodium solution (antibiotic) 1 gram intravenously (IV) every 24 hours for infection, complicated urinary tract infection, for four days. Review of the Medication Administration Record (MAR) revealed the last dose of ertapenem was administered on 10/1/24 at 6:01 PM. On 10/02/24 at 8:28 AM, Registered Nurse (RN) F was observed preparing and administering ertapenem 1 gram/100 milliliters IV over one hour through a peripherally inserted central catheter (PICC line). The dose was administered approximately 14.5 hours after the last dose. RN F reported R36's antibiotic was delivered late on 10/1/24 and therefore given after the scheduled time. RN F agreed R36 received the last dose the evening before and that it had not yet been 24 hours. In an interview on 10/02/24 at 10:36 AM, Director of Nursing (DON) B reported R36 was ordered to receive ertapenem every 24 hours. DON B agreed R36 received a dose on 10/1/24 at 6:01 PM and then again, the morning of 10/2/24, approximately 14.5 hours later. DON B reported they would expect the timing of the order to be changed after the first dose was administered late. 38383 Resident #22 (R22) Review of the medical record reflected R22 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included type 2 diabetes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 07:38 AM, Registered Nurse (RN) D was observed to begin preparing medications for R22, including Tresiba FlexTouch 100 units per milliliter (u/mL) (long-acting insulin pen). Without placing a needle on the insulin pen, RN D turned the dose selector to two units, then pressed the injection button. RN D stated she always pushed two units of air out of the pen. She then applied a needle to the insulin pen and turned the dose selector to R22's prescribed dose of 55 units. On 10/02/24 at 08:36 AM, RN D reported she usually primed insulin pens without a needle on the pen. RN D could not recall if that was how she had been trained. In an interview on 10/02/24 at 10:36 AM, Director of Nursing (DON) B described that priming an insulin pen consisted of placing a needle on the insulin pen, setting the dose selector to two units and pressing the injection button. The insulin pen would then be set to the prescribed dose for administration. According to Cleveland Clinic, .Prime the insulin pen. Priming means removing air bubbles from the needle. It ensures that the needle is open and working. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. You may need to repeat this step until a drop appears . (https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections)

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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** 38905 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents who consume food from the kitchen with a current facility census of 62 residents. Findings include: During a tour of the kitchen, starting at 9:00 AM on 10/1/24, it was observed that the top portion of the gasket, on the left door of the Raetone three door refrigeration unit, was found to have an accumulation of spotted debris. During a tour of the kitchen, at 9:15 AM on 10/1/24, it was observed that the underside of the juice machine was found with fuzzy and sticky debris between the spouts of the unit, especially in and around areas where screws are located. When showed to Regional Dietary Manager (RDM) V, he stated they would get them cleaned. During a tour of the kitchen, at 9:17 AM on 10/1/24, observation under the single compartment preparation sink found water accumulation that spanned under the juice and coffee area, the hand sink, and under the three-door refrigeration unit. Further observation found that the air gap to the preparation sink was not installed in a manner that made it easy for staff to dispense the sink when finished and would routinely cause water to accumulate on the floor. At this time, observation of the dish machine air gap also found that it caused excess splash onto the floor. These air gaps should prevent contamination from backflow, but also be installed in a manner that causes minimal issues with general cleaning and environment of the kitchen. During a tour of the kitchen, at 9:20 AM on 10/1/24, it was found that accumulation of debris, dirt, and some stagnant water, had found its way behind the three large cold hold units along the back of the floor juncture. Observation found two of the units are on fitted legs and one unit has [NAME] wheels. Observation of the three-compartment sink area, at 9:35 AM on 10/1/24, found a shelf above the three compartment sink, next to the cook line, that was used for storing half and quarter size stainless steel pans. Feeling the stacked pans, found that they were covered in a greasy substance and not clean. When asked why the pans were in this location, RDM V was unsure, and stated he would cleaned the area, and move the pans to the storage rack near the back of the kitchen with other pots and pans. Observation of the ice machine area, at 10:05 AM on 10/1/24, found accumulation of dust and dirt debris behind the ice machine as well as plastic wrapping and Styrofoam cups. During a revisit to the kitchen, at 11:35 AM on 10/1/24, it was observed that a 14-inch saucepan was on the stove top for cooking grilled cheese. Observation of the saucepan found heavy encrusted grease deposits which blackened most of the cooking surface of the pan, leaving minimal stainless steel visible. When asked if there were other pans that could be used, [NAME] X stated it was the only one they had to use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235285	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Lansing	731 Starkweather Dr Lansing, MI 48917

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (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. According to the 2017 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. 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 . Observation of Activities Aide Y at 10:07 AM on 10/1/24, found they used the hand wash sink faucet, near the ice machine, in order to fill a cup of water. An interview with RDM V found that staff should not use the hand sink for water pass and that the facility has a water dispenser right next to the ice machine. When questioned why the water dispenser wasn't used, staff had stated at this time that the water spigot for water pass comes out slow compared to the hand sink. According to the 2017 FDA Food Code section 5-205.11 Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use.(B) A HANDWASHING SINK may not be used for purposes other than handwashing . A revisit to the kitchen, at 12:06 PM on 10/1/24, observed staff plating meal service for lunch. As meals were being plated in the kitchen and passed through a window, Staff on the other side of the window were checking tickets and stacking meal trays on carts. At this time, some grilled cheeses were requested to be made and Dietary Manager in Training (DMT) W came from outside the kitchen, put on gloves, and started making two grilled cheese. No observation of hand sink use was found after entering the kitchen and starting food preparation. According to the 2017 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and . (H) Before donning gloves to initiate a task that involves working with FOOD; .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough space and equipment to meet each resident's needs 38905 Based on observation and interview the facility failed to provide and maintain therapy equipment in a manner that would allow for safe and consistent operation that meets the needs of all residents. Findings Include: An interview with Physical Therapy Manager (PTM) U, at 2:50 PM on 10/1/24, found that some equipment in therapy has not been working properly for all residents. When asked what issues have been occurring, PTM U went on to state that the parallel bars are not wide enough to be used properly for our residents who are bariatric. When asked how they are used for those residents now, PTM U stated that those residents have to use the side of the parallel bars and that makes them unable to use both sides to stabilize as they walk down. When asked about any other equipment, PTM U stated that the ScitFit elliptical bike doesn't seem to be working properly and that the resistance doesn't increase sometimes as the dial gets turned up. PTM U stated that some residents have noticed that as they want to increase the resistance and work harder on their recovery, the bike doesn't seem to aid in a way that allows for those residents to achieve their goals. During a tour of therapy, at 2:55 PM on 10/1/24, an interview with Physical Therapy Aide Z, found that the therapy department uses the kitchenette area in therapy for residents. At this time, the stove top oven was able to be turned on with the dials on the back of the unit and was getting hot quickly. An interview with Maintenance Director S found that there is a control panel shut off for the stove and it should be locked out whenever it is not in use. At this time, Maintenance Director S went and shut off the breaker and stated he would be putting a lock on the breaker from now on.