STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235290	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Greenville	828 E Washington St Greenville, MI 48838

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00144334 Based on observation, interview, and record review, the facility to failed to ensure that 1.) call lights were within reach and answered promptly and 2.) ensure resident needs were met in a timely manner for 3 residents (Residents #18, #37, and #50) of 20 residents reviewed for accommodation of needs, resulting in pain/discomfort and the inability to call staff for assistance. Findings: Resident #18 (R18) Review of an Admission Record revealed R18 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: quadriplegia. Review of R18's Care Plan revealed, I have an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) quadriplegia, ventilator dependence, chronic respiratory failure, BEHCET'S DISEASE (blood vessel inflammation throughout the body), contracture to bilateral hips and knees (present on admission), pain . * Bed Mobility- I need 2 person assist. Date Initiated: 12/22/2022 . * TRANSFER: I require total assistance with transfers. Date Initiated: 12/22/2022 * MOBILITY: I use a wheelchair for locomotion . Date Initiated: 12/16/2022 . *TRANSFERRING- hoyer Date Initiated: 05/11/2024 . I am Ventilator dependent r/t chronic respiratory failure .Keep call bell within reach. Date Initiated: 03/10/2023 . I am at risk for psychosocial well-being problems r/t Illness/Disease Process (CHRONIC RESPIRATORY FAILURE WITH HYPOXIA, vent dependent), Inability to meet role expectations, Social isolation, Limited communication abilities and full dependence on others for all daily care/ADLs Increase communication about care and living environment. ASK ME HOW I FEEL ABOUT THEM Date Initiated: 06/13/2023. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/04/24 at 09:21 AM, R18 was in the 2nd bed in the double room which was located near the window and away from the door. R18 appeared anxious and frustrated. He was alert and oriented and able to communicate his concerns by mouthing words (due to the use of the ventilator, there was no speaking valve in place on his tracheostomy for him to produce sound through his vocal cords). R18 was asked if he required assistance, and he nodded his head yes. When asked if he had his call light, he nodded his head no. When asked if he knew where his call light was, he nodded his head no. R18's call light was not visible and was entirely obscured by the privacy curtain (clipped to the center of the privacy curtain which was then pushed against the wall). R18 reported (by mouthing words) that without the availability of his call light and his inability to call for help, he had feelings of helplessness and fear because he would not be able to request assistance in the event of an emergency. R18 reported that this was not the first time his call light was out of reach and stated he was left to the mercy of the staff and would have to wait until they rounded (approximately every 2 hours) if he required assistance. R18 reported that he was experiencing pain in his buttocks from being in the same position for an extended period of time and needed assistance with repositioning to alleviate his pain, but he had not been able to find his call light. R18 reported staff had not been getting him up to his wheelchair when he requested and stated he was sick of being in bed. During an interview on 06/04/24 at 09:21 AM, Unit Manager (UM) F reported that R18's call light should be in reach at all times, and she would ensure staff were reeducated. During an observation and interview on 06/04/24 at 09:46 AM, Contracted Wound Physician Assistant (CWPA) N reported that R18 had a full thickness friction skin injury on his bilateral buttocks that was still present but was improving. CWPA N reported that she had not made recommendations to limit R18's time up in his broda chair to prevent the worsening of his skin injury. During an interview on 06/05/24 at 10:06 AM, Registered Respiratory Therapist (RRT) M reported R18 was medically stable and able to safely transfer to his broda chair as he requested. RRT M did not report any medical rationale for R18 to remain in bed or to limit R18's time in the broda chair. Review of R18's Practitioner Progress Note dated 5/31/24 revealed, .He is alert oriented and able to answer questions very well. We talked about diaphragmatic fatigue and will need to watch for this closely. He knows when he feels tired and goes back on the vent . Confirming the need for the call light to be within reach in the event of a respiratory emergency. On 6/5/24 at 10:32 AM, 6/5/24 at 11:52 AM, and 6/5/24 at 12:56 PM documentation regarding the use of R18's broda chair was requested. Specifically, documentation of when R18 was up in the chair, how long he was up, and how it was tolerated to ensure R18's requests to be up in his broda chair were honored. No documentation was received prior to survey exit. 45410 Resident #37 Review of an Admission Record revealed Resident #37 admitted to the facility on [DATE] with pertinent diagnoses which included morbid obesity and dependence on a wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #37, with a reference date of 3/4/2024 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #37 was cognitively intact. In an observation and interview on 6/3/2024 at 11:10 AM in Resident #37's room, Resident #37 was in bed and reported frustration that she cannot get out of bed when she requests. Resident #37 reported she is routinely told by staff that she could not get out of bed because there were not enough staff to assist her. Resident #37 reported she only got out of bed for showers and appointments. In an interview on 6/4/2024 at 3:41 PM, Resident #37 reported certain nursing assistants tell her that they cannot get her up because of staffing levels. Resident #37 reported Corporate Consultant (CC) A discussed this with her and told her that there are enough staff to get her up when she requests. In an interview on 6/4/2024 at 3:50 PM, Certified Nursing Assistant (CNA) L reported there are now only 3 CNA's working on the east and west halls and they do not always have time to get Resident #37 out of bed. CNA L reported that it depends on what is going on and how busy everyone is. In an interview on 6/4/2024 at 4:00 PM, Registered Nurse (RN) G reported sometimes aides take a break an hour into their shift, which can affect the ability to get things done the rest of their shift. RN G stated, they should not be thinking about a break until at least 8:30. In an interview on 6/4/2024 at 4:05 PM, Corporate Consultant (CC) A reported the team had a discussion with Resident #37 regarding her complaint about not being able to get up when she requests. CC A reported there should always be enough staff to get Resident #37 out of bed, especially on weekdays with unit managers and other staff around. Resident #50 Review of an Admission Record revealed Resident #50 admitted to the facility on [DATE] with pertinent diagnoses which included multiple sclerosis, obesity, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #50, with a reference date of 3/26/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #50 was cognitively intact. Further review of same MDS assessment revealed Resident #50 required substantial assistance with toileting and transfers. Review of a current activities of daily living Care Plan intervention for Resident #50, initiated 3/29/2024, directed staff that Resident #50 required the assistance of 2 persons with toileting. In an interview on 6/3/2024 at 11:33 AM, Resident #50 reported about twice a week he waited 30 minutes for toileting assistance after pressing his call light. Resident #50 reported two days prior he had a bowel movement in his wheelchair, went to his room and pressed his call light, and it took 30 minutes for someone to come for assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interiew on 6/5/2024 at 8:09 AM, Resident #50 reported he pressed the call light between 9 and 11 PM the previous evening and it took 30 to 40 minutes for staff to come assist him getting off the bedpan. Resident #50 stated, it hurts when you sit there that long, they say you should only be on it for 15 minutes.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00144334 Based on interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for 4 of 13 residents (Resident #38, #68, #1, and #23), reviewed for the provision of nursing services, resulting in medication errors and medications being administered outside of the physician ordered parameters. Findings: Resident #38 (R38) Review of an Admission Record revealed R38 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension (high blood pressure). Review of R38's Order Summary dated 5/9/23 revealed, Sildenafil Citrate Oral Tablet 20 MG (Sildenafil Citrate (Pulmonary Hypertension)) Give 20 mg by mouth three times a day for HTN (hypertension) hold if SBP <100 (systolic blood pressure/top number is less than 100). Indicating a blood pressure assessment would be completed prior to each administration of the sildenafil (3 blood pressure assessments each day). This medication was to be administered in the morning, at noon, and in the evening. Review of R38's April Medication Administration Record (MAR) revealed: *On 4/4/24 R38's blood pressure was assessed only 1 time at 7:07 AM with the same blood pressure result documented for all 3 administrations indicating 2 falsified/inaccurate blood pressure results were documented in the MAR to show the blood pressure had been assessed prior to the noon and evening administration of the sildenafil. *On 4/7/24 at 7:26 AM R38's blood pressure was 96/62 and the morning dose of sildenafil was administered. *On 4/9/24 R38's blood pressure was assessed only 2 times at 6:37 AM and 5:59 PM. The blood pressure result obtained for the morning dose was also documented for the noon dose indicating a falsified/inaccurate blood pressure result was documented in the MAR prior to the administration of the sildenafil. *On 4/16/24 R38's blood pressure was assessed only 2 times at 6:36 AM and 7:11 PM. *On 4/17/24 R38's blood pressure was assessed only 2 times at 6:54 AM and 7:09 PM. At 6:54 AM R38's blood pressure was 94/58 and the morning dose of sildenafil was administered. R38's blood pressure was not reassessed for the noon dose and the sildenafil was again administered (with a blood pressure that was outside of parameters). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 4/18/24 R38's blood pressure was assessed only 2 times at 7:18 Am and 8:54 PM. The blood pressure result obtained for the morning dose was documented for the noon dose. Indicating a falsified/inaccurate blood pressure result was documented in the MAR prior to the administration of the sildenafil. *On 4/27/24 R38's blood pressure was assessed only 1 time at 6:50 AM. The blood pressure result obtained for the morning dose was documented for the noon dose. Indicating a falsified/inaccurate blood pressure result was documented in the MAR prior to the administration of the sildenafil. *On 4/28/24 R38's blood pressure was assessed only 2 times at 6:57 AM and 7:43 PM. The blood pressure result obtained for the morning dose was documented for the noon dose. Indicating a falsified/inaccurate blood pressure result was documented in the MAR prior to the administration of the sildenafil. Review of R38's May Medication Administration Record revealed: *On 5/3/24 R38's blood pressure was 98/63 at 7:12 AM. The morning dose of sildenafil was held. The blood pressure result obtained for the morning dose was documented for the noon and evening dose. Indicating falsified/inaccurate blood pressure results were documented in the MAR which resulted in the withholding of the sildenafil. *On 5/11/24 R38's blood pressure was 93/65 at 6:51 AM. The morning dose of sildenafil was not administered. The blood pressure result obtained for the morning dose was documented for the noon and evening dose. Indicating falsified/inaccurate blood pressure results were documented in the MAR. However, the noon and evening dose was administered. Review of the Blood Pressure Summary confirmed only 1 blood pressure assessment was completed on 4/4/24, 4/27/24, 5/3/24, and 5/11/24 and only 2 blood pressure assessments were completed on 4/9/24, 4/17/24, 4/18/24, and 4/28/24. During an interview on 06/05/24 at 01:18 PM, Director of Nursing (DON) confirmed the medication was administered outside of the ordered parameters and reported R38's blood pressure should have been assessed prior to each administration of sildenafil. Resident #68 (R68) Review of an Admission Record revealed R68 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension. Review of R68's Order Summary dated 3/5/24 revealed, Amiodarone HCl Tablet 200 MG Give 1 tablet via GTube one time a day for HTN hold if SBP less then 90 or HR (heart rate) less then 60. Review of R68's April Medication Administration Record revealed: *On 4/16/24 R68's heart rate was 54 and the amiodarone was administered *On 4/17/24 R68's heart rate was 58 and the amiodarone was administered (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 4/23/24 R68's blood pressure was 82/40 and the amiodarone was administered *On 4/28/24 R68's blood pressure was 83/52 and the amiodarone was administered Review of R68's May Medication Administration Record revealed: *On 5/7/24 R68's blood pressure was 63/40 and the amiodarone was administered *On 5/21/24 R68's blood pressure was 83/41 and the amiodarone was administered Resident #1 (R1) Review of an Admission Record revealed R1 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension and seizures. Review of R1's Order Summary dated 3/25/24 revealed, Lacosamide Oral Tablet 150 MG (Lacosamide) Give 150 mg via G-Tube two times a day for seizures. To be administered at 5:00 AM and 5:00 PM. Review of R1's Controlled Substance Proof of Use Record revealed that on 5/10/24 R1 received only 1 dose of lacosamide at 5:28 PM. Review of R1's May Medication Administration Record revealed that on 5/10/24 both the 5:00 AM and 5:00 PM doses of lacosamide were documented as administered. During an interview on 06/05/24 at 01:18 PM, DON confirmed the medication error for R1 and reported a medication error incident reports and 1 on 1 education to the nurse was completed. Resident #23 (R23) Review of an Admission Record revealed R23 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: seizures. Review of R23's Order Summary dated 3/25/24 revealed, Brivaracetam Oral Solution 10 MG/ML (Brivaracetam) Give 10 ml via G-Tube two times a day for seizures. To be administered at 8:00 AM and 8:00 PM. Review of R23's Controlled Substance Proof of Use Record revealed that on 5/25/24 R23 received only 1 dose of brivaracetam at 9:56 AM. On 5/27/24, between the 8:00 AM dose and 8:00 PM of brivaracetam, an entry dated 5/25/24 and time 7:54 PM documenting the brivaracetam was administered. Note the narcotic count/count remaining from 5/25/24 did not reveal a discrepancy. Indicating the medication was not administered on 5/25/24. Review of R23's May Medication Administration Record revealed that on 5/25/24 both the 8:00 AM and 8:00 PM doses of brivaracetam were documented as administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 01:18 PM, DON confirmed the medication error for R23 and reported a medication error incident report and 1 on 1 education to the nurse was completed. DON reported that the nurse responsible for the medication error reported that she administered the medication but forgot to sign it out and documented that she administered it during her next shift. DON confirmed that the count/amount remaining would have been inaccurate had the nurse administered the medication and would have been identified during shift change narcotic count. During an interview on 06/05/24 at 10:32 AM, Licensed Practical Nurse (LPN) O reported that the nurse administering medications was responsible for obtaining vital signs prior to the administration of medications that had ordered parameters. LPN O reported that if a medication with blood pressure parameters was ordered to be administered 3 times a day a blood pressure would be obtained prior to each administration. LPN O reported that the Electronic Health Record would prompt nurses to obtain the vital signs. During an interview on 06/05/24 at 01:18 PM, DON reported she was not aware that nurses were administering medications outside of the ordered parameters and reported the expectation of the licensed nurses was to hold/administer medications following the physician orders. Review of the facility policy Medication Administration-General Guidelines dated June 2019 revealed, .B. Administration .2) Medications are administered in accordance with written orders of the prescriber . Review of the facility policy Controlled Substances dated June 2019 revealed, .D. Accurate accountability of the inventory of all controlled substances in maintained at all times. When a controlled substance is administered, the nurse administering the medication immediately enters the following information on the controlled substance count sheet and on the Medication Administration Record (MAR): 1. Date and time of administration .2. Amount administered .3)Remaining quantity . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, (Nurses) are responsible for documenting any preassessment data required of certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Legal Guidelines for Documentation . Errors in recording can lead to errors in treatment or may imply an attempt to mislead or hide evidence . Record must be accurate, factual, and objective. Be certain that each entry is thorough. A person reading your documentation needs to be able to determine that a patient received adequate care. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 366). Elsevier Health Sciences. Kindle Edition.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to adequately monitor a resident after a fall with head injury for 1 resident (Resident #27) of 1 resident reviewed for falls, resulting in inadequate monitoring and the potential for unnoticed and untreated physical injury, and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #27 admitted to the facility on [DATE] with pertinent diagnoses which included dementia, cerebral infarction (stroke), and hemiplegia (one sided paralysis) affecting the left side. Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 3/11/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #27 was cognitively intact. Review of a current fall Care Plan focus for Resident #27, initiated 12/7/2023, revealed Resident #27 was at an increased risk for falls related to generalized weakness, impaired cognition, and use of psychotropic and anticoagulant medication. In an observation and interview on 6/3/2024 in Resident #27's room, Resident #27 had a large hematoma and sutures on her left forehead, her left eye was reddened from bruising, and her left knee was swollen. Resident #27 reported she fell the previous night and was sent to the hospital for treatment. Resident #27 was not sure how often staff were checking on her since she returned from the hospital. Review of Resident #27's Post Fall Assessment, dated 6/3/2024 at 4:21 AM, revealed Resident #27 had an unwitnessed fall at 3:40 AM and sustained injuries including a laceration to her forehead, left eye bruising, a left shoulder skin tear, and a bruise to her left knee. Further review revealed the Post Fall Assessment form instructed staff to initiate neuro checks after if unwitnessed fall or head injury. Further review indicated Resident #27 was on anticoagulant therapy. Review of Resident #27's Neurological Assessment Flowsheet, dated 6/3/2024, revealed neurological checks were initiated but discontinued because resident returned from the hospital with negative CT's (testing showing the resident did not have evidence of an intracranial bleed at that time). In a telephone interview on 6/4/2024 at 1:25 PM, Licensed Practical Nurse (LPN) J reported she was working the morning Resident #27 returned from the hospital. LPN J reported CT's and x-rays were normal and a reputable nurse, she forgot whom, told her that residents do not require neurological checks after a head injury if their CT was normal. LPN J reported she notified Physician's Assistant (PA) C of Resident 27's status and return from the hospital and PA C was planning to evaluate Resident #27 that shift. LPN J reported she did not discuss neurological checks with PA C and she did not receive an order to stop neurological checks for Resident #27. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 6/4/2024 at 1:50 PM, Registered Nurse (RN) D reported she was not taking care of Resident #27 when she returned from the hospital after her fall and was not a part of any discussions regarding Resident #27's treatment plan. RN D stated, I would normally do neuro checks after a head injury even if they come back from the hospital because not everything shows up right away. RN D reported she was not sure if there was a facility policy or procedure that covered neurological checks. In a telephone interview on 6/4/2024 at 1:59 PM, PA C reported she was busy the morning Resident #27 returned from the hospital after her fall and did not have time to evaluate her. In an interview on 6/4/2024 at 2:15 PM, the Director of Nursing (DON) reported neurological checks were not completed for Resident #27 after she returned from the hospital and there was no facility policy or procedure directing staff when to complete neurological checks. The DON reported she was not aware of any recent direction to staff regarding neurological checks or when to complete or discontinue neurological checks. In a telephone interview on 6/4/2024 at 2:33 PM, PA C stated, I am new to this role, staff should follow policy. PA C reported she received report from the nurse upon Resident #27's return from the hospital, but they did not discuss stopping neurological checks. PA C reported the conservative approach would have been to continue neurological checks as intracranial bleeds can happen slowly after the initial injury. In an interview on 6/4/2024 at 4:34 PM, Corporate Consultant (CC) A reviewed the Post Fall Assessment form which stated if unwitnessed fall or head injury, initiate neuro checks. CC A reported she was beginning education with staff regarding when to complete neurological checks and will clarify policy with her team as there was no policy or procedure and this needed to be addressed. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, You perform a reassessment when a patient's condition changes, as it improves or worsens .A disorganized approach could cause errors and incomplete findings. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 517). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Completing a health assessment and physical examination is an important step toward providing safe and competent nursing care. The nurse is in a unique position to determine each patient's current health status, distinguish variations from the norm, and recognize improvements or deterioration in the patient's condition. Nurses must be able to recognize and interpret each patient's behavioral and physical presentation. You perform health assessments and physical examinations to identify health patterns and evaluate each patient's response to treatments and therapies. You gather assessment data about patients' past and current health conditions in a variety of ways, using a comprehensive or focused approach, depending on the patient situation .Depending on the outcome of an assessment, a nurse considers evidence-based recommendations for care based on a patient's values, the health provider's clinical expertise, or personal experience. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 516-517). Elsevier Health Sciences. Kindle Edition. Review of facility policy/procedure Fall Reduction Policy, reviewed April of 2023, revealed .When any resident experiences a fall, the facility will . Assess the resident . Complete a Post-Fall Assessment .

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	235290	A. Building B. Wing	06/05/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to properly secure resident medications for 1 resident (Resident #435) of 5 residents whose medications were reviewed, resulting in unsecured medication the potential for cross contamination, and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #435 admitted to the facility on [DATE] with pertinent diagnoses which included Parkinson's Disease and dementia. Review of a Minimum Data Set (MDS) assessment for Resident #435, with a reference date of 6/3/2024 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #435 was moderately cognitively impaired. Review of a current Care Plan focus for Resident #435, initiated 5/29/2024, notified staff that Resident #435 was moderately cognitively impaired, had poor short-term memory, and was only partially oriented to time and place. In an observation on 6/3/2024 at 10:15 AM in Resident #435's room, prescription Triad cream (a wound creme with zinc oxide) was within reach of Resident #435 on the bedside table at the foot of his bed. In an observation on 6/4/2024 at 7:29 AM in Resident #435's room, Triad cream remained within reach of Resident #435 on the bedside table at the foot of his bed. In an observation on 6/5/2024 at 7:46 AM in Resident #435's room, Triad cream remained within reach of Resident #435 on the bedside table at the foot of his bed. In an observation and interview on 6/5/2024 at 7:51 AM in Resident #435's room, Triad cream was sitting on Resident #435's bedside table and another tube of Triad creme was found in his bedside drawer. Registered Nurse (RN) K reported Triad creme is required to be stored in the treatment cart and Resident #435 had not been evaluated for self administration of medication. In an interview on 6/5/2024 at 9:28 AM, RN Unit Manager Q reported treatment creams should not be stored in resident rooms unless there was a resident assessment on file that deemed him safe to self administer the cream. In at interview on 6/5/2024 at 9:52 AM, Corporate Consultant (CC) A reported the Triad cream in Resident #435's room came from the hospital and should not have been in his room. CC A reported she would be educating staff regarding proper storage of treatment creams.

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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. 39083 Based on observation, interview, and record review, the facility failed to maintain dish machine sanitization and maintain clean food contact surfaces, resulting in the increased risk of food borne illness, affecting all residents that consume food from the kitchen. Findings include: On 6/3/24 at 1:58 PM, during an inspection of the kitchen, assisted by Dietary Manager T, dietary staff were observed to be washing dishes in the dish machine. The dish machine chlorine sanitizer concentration was tested using color indicating test strips and no sanitizer was detected. At this time, Dietary Manager T stated that the dish machine used to use hot water as a sanitizing method but the water temperature was too inconsistent. The hot water rinse of the dish machine was tested using a plate simulating thermometer and was found to be 143 degrees. Dietary Manager T stated they will use the three-compartment sink to wash dishes until the dish machine can be serviced. During an interview on 6/4/24 at 1:18 PM, Dietary Manager T stated that a technician serviced the dish machine but the sanitizer is still inconsistent. Dietary Manager T continued to say that they are testing the sanitizer concentration frequently to ensure proper sanitization until the technician can come back out. According to the 2017 FDA Food Code Section 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under S7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart; P Concentration Range (mg/L) 25-49, 50-99, 100 Minimum Temperature pH 10 or less [Celsius] ([Fahrenheit]) 49 (120), 38 (100), 13 (55) Minimum Temperature pH 8 or less [Celsius] ([Fahrenheit]) 49 (120), 24 (75), 13 (55) On 6/3/24 at 2:10 PM, four chaffing pans, located on the wire rack next to the three-compartment sink, were observed to be stored wet, in a position that doesn't allow for proper air drying. At this time, Dietary Manager T confirmed the finding and removed the wet chaffing pans. (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 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. (C) SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored as specified under (A) of this section and shall be kept in the original protective PACKAGE or stored by using other means that afford protection from contamination until used. (D) Items that are kept in closed PACKAGES may be stored less than 15 cm (6 inches) above the floor on dollies, pallets, racks, and skids that are designed as specified under S 4-204. 122. On 6/3/24 at 2:15 PM, three mechanical scoops, stored in the prep table drawer, were observed to be wet and soiled with food debris. At this time, Dietary Manager T confirmed the finding and removed the scoops to be re-washed. 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. Pf (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.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 Based on interview and record review, the facility failed to assess and monitor an infection for 1 of 2 residents (Resident #25) reviewed for antibiotic use. This deficient practice resulted in Resident #25 going unassessed and monitored with the potential for further decline and complications from an infection. Findings include: The facility provided a copy of the Antibiotic Stewardship Program dated 4/2017 and last revised on 1/2024 for review. The policy reflected, The program includes antibiotic use protocols and system to monitor antibiotic use. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection and notify the physician as applicable. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses the McGeer's Criteria to define infections . Resident #25 (R25) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R25 admitted to the facility on [DATE] with diagnosis of (but not limited to) Chronic Obstructive Pulmonary disease, high blood pressure, and a history of urinary tract infections. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R25 was cognitively intact. According to the care plan for history of recurrent urinary tract infections r/t (related to incontinence dated 10/11/23 reflected the following intervention of, Report signs of infection such as fever, chills, flank, pubic pain, change in urine character, urgency, frequency, decreased voiding, increased confusion to the nurse/MD (medical doctor) dated 10/11/23. The care plan reflected R25 required staff assistance with all activities of daily living. According to a laboratory report dated 5/3/24 at 1:13 PM a urine sample was collected, and initial report reflected a positive urinary tract infection (UTI). It was subsequently sent for culture and sensitivity. The final report was resulted on 5/6/24 at 9:19 AM. There were greater than 100,000 CFU/ml Klebsiella pneumonia and Escherichia coli. The organisms were susceptible to Ciprofloxacin. According to the Medication Administration Record (MAR) for May 2024 reflected that R25 received Ciprofloxacin 500 mg twice daily from 5/7/24 PM until the AM of 5/14/24. Review of the temperature log from 4/30/24 - 5/8/24 reflected the following temperatures logged: 4/30/24 97.8 5/4/24 97.2 5/8/24 97.8 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes from 5/3/24 until 5/7/24 did not contain twice daily monitoring of symptoms and vital signs of the UTI. During an interview and record review on 6/5/24 at 11:04 AM, the Infection Control Preventionist (ICP) F stated if the staff suspect an infection, they should follow the policy to obtain an order for a urinalysis with culture and sensitivity if indicated. When asked if the doctors order could be located in the electronic medical record (HER), ICP F stated she was not able to locate it. When asked how staff should monitor residents who they suspect has an infection, ICP F stated she expected staff to monitor all potential infections by obtaining a set of vital signs, checking for signs and symptoms twice daily and documenting it in the progress notes. ICP F reviewed the vital signs, temperature log and progress notes from 5/3/24 - 5/7/24 and was unable to locate the documented assessments. ICP F stated she would double check the record for the information. No further documents were provided for review prior to the exit of this survey.