STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235310	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Porter Hills Health Center	3600 Fulton St E Grand Rapids, MI 49546

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 36221 Based on interview, and record review, the facility failed to accurately complete Minimum Data Set (MDS) assessments in 2 of 12 residents (Resident #18 & #33) reviewed for accuracy of assessments, resulting in an inaccurate reflection of the resident's status. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.18.11, Chapter 3 Section O: Special Treatments, Procedures, and Programs, revealed .The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods .The treatments, procedures, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life .Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs .Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider . Resident #18 Review of an Admission Record revealed Resident #18 was a female, with pertinent diagnoses which included Alzheimer's disease, dementia, anxiety, depression, Parkinson's disease, diabetes, high blood pressure, heart disease, and arthritis. Review of an Order Summary Report for Resident #18 revealed the active physician order .Hospice to treat . with a start date of 1/22/24. Review of a current Care Plan for Resident #18 revealed the focus .I have a terminal prognosis r/t (related to) Alzheimer's Disease . revised 1/31/24, with interventions which included .I am on hospice care. Adjust provision of ADLS (Activities of Daily Living) to compensate for my changing abilities. Encourage (participation) to the extent I wish to participate . initiated 1/31/24. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #18, with a reference date of 4/12/24, revealed the Section O0110. Special Treatments, Procedures, and Programs, K1. Hospice care was marked No for While a Resident. In an interview on 8/1/24 at 11:07 AM, Nurse Manager E reported Resident #18 admitted to the facility on Hospice care, and has remained on Hospice for the duration of her stay. Nurse Manager E reported that the MDS Assessment for Resident #18, with a reference date of 4/12/24, should have Hospice care marked Yes and would need to be corrected. Resident #33 Review of an Admission Record revealed Resident #33 was a male, with pertinent diagnoses which included Alzheimer's disease, dementia, anxiety, and heart disease. Review of an Order Summary Report for Resident #33 revealed the active physician order .Admit to (Company Name) Hospice Services . with a start date of 4/2/24. Review of a current Care Plan for Resident #33 revealed the focus .I have a terminal prognosis r/t (related to) Alzheimer's Disease . revised 4/2/24, with interventions which included .I am on hospice care. Adjust provision of ADLS (Activities of Daily Living) to compensate for my changing abilities. Encourage (particpation) to the extent I wish to participate . initiated 4/2/24. Review of a Minimum Data Set (MDS) assessment for Resident #33, with a reference date of 4/12/24, revealed the Section O0110. Special Treatments, Procedures, and Programs, K1. Hospice care was marked No for While a Resident. In an interview on 8/1/24 at 12:58 PM, Nurse Manager E reported that she is responsible for completion of the MDS assessments. Nurse Manager E reported the information in regard to Hospice is manually entered into the MDS assessments. Nurse Manager E reported Resident #33's MDS assessment, with a reference date of 4/12/24, was a Significant Change assessment due to his enrollment with Hospice care, and the question about Hospice care in Section O should have been marked Yes and would need to be corrected.

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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** 36221 Based on observation, interview, and record review, the facility failed to update/revise a comprehensive care plan after a change in resident condition in 3 of 12 residents (Resident #18, #8, & #37) reviewed for comprehensive care plans, resulting in an inaccurate reflection of the resident's status, and the potential for unmet medical, physical, mental, and psychosocial needs. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.18.11, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care . Resident #18 Review of an Admission Record revealed Resident #18 was a female, with pertinent diagnoses which included Alzheimer's disease, dementia, anxiety, major depression with psychotic symptoms, insomnia, Parkinson's disease, and claustrophobia. Review of a Hospice Interdisciplinary Group Conference Communication note for Resident #18, dated 6/27/24, revealed .writer informed by staff nurse .that patient having episode of extreme agitation and restlessness, and that they are unable to redirect patient. Writer also attempted to verbally redirect and de-escalate patient, she was repeatedly tearful and demanding that staff push her around (in) wheelchair, however, due to patients positioning, she was only half seated (in) wheelchair and staff and writer tried to explain that they could not push her until she sat further back in the wheelchair, further angering patient . (Nurse Manager E) contacted facility physician and received new order for 1 mg haldol scheduled every 3 hours, as well as to discontinue scheduled seroquel . Review of an Order Summary Report for Resident #18 revealed the physician order .SEROquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 2 tablet by mouth two times a day for anxiety, psychosis . which was ordered on 6/3/24 had a status of discontinued. Review of an Order Summary Report for Resident #18 revealed the active physician order Haloperidol Lactate Concentrate 2 MG/ML Give 0.5 milliliter by mouth every 3 hours . with a start date of 6/27/24. No active order noted for Seroquel. Review of a Health Status Note for Resident #18, dated 7/3/24, revealed .Resident doing well on new medication change to Haldol. Resident is enjoying activities with many of the resident and eating with them. Resident is less anxious and smiles more frequently . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 7/31/24 at 11:47 AM, Registered Nurse (RN) L prepared and administered 0.5 mL of Haloperidol Lactate Concentrate 2 MG/ML to Resident #18 at the medication cart. Noted Resident #18 took the medication with no issue. No negative mood or behaviors noted at this time. Review of a current Care Plan for Resident #18 revealed the focus .I use antipsychotic medication .r/t (related to) psychosis, depression. I am prescribed Seroquel . revised 4/22/24, with interventions which included .I am getting (an) increase in Seroquel for my hallucinations . initiated 6/3/24. Note the Seroquel for Resident #18 was discontinued on 6/27/24. In an interview on 8/1/24 at 11:07 AM, Nurse Manager E reported Resident #18 is .much more stable . after the medication change from Seroquel to Haldol on 6/27/24. Nurse Manager E reported they attempted to increase Resident #18's Seroquel dose prior to the medication change, however, the increased dose did not reduce Resident #18's episodes of tearfulness and anxiety. Nurse Manager E reported Care Plans should be updated by the Interdisciplinary Team after changes in resident condition/status. According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences.A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings .The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures. Nurses revise a plan when a patient's status changes . The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care . 30337 Resident #8 (R8) On 7/30/2024 at 11:00 AM, R8 was observed sitting in a wheelchair in her room and asked what the objects were that she saw from her window; R8 was not wearing glasses. R8's Minimum Data Set (MDS) with an assessment reference date of 5/13/2024 revealed she was admitted to the facility on [DATE] and had a Brief Interview for Mental Status, (BIMS) a brief cognitive screener score of 06 (00-07 Severe Cognitive Impairment). The same MDS assessment revealed R8 had the diagnoses of glaucoma, diabetes mellitus, and dementia. In review of R8's medical record, she had an eye exam on 6/05/2024 and eyeglasses with bifocals were ordered. Progress Notes dated 6/16/2024 at 11:16 AM revealed R8 received eyeglasses with a light purple frame in a black case. In review of R8's care plans, there was no mention she wore glasses. Nurse Manager (NM) E was interviewed on 7/31/2024 at 1:18 PM and stated R8 did not wear glasses. After review of R8's medical record, NM E stated the nurse should have updated R8's care plan when she received her glasses and would have to do some education with the nurse. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nurse Assistant (CNA) H was interviewed on 8/01/2024 at 11:38 AM and stated she had been caring for R8 for a few weeks and haven't seen any glasses for her. Resident #37 (R37) In review of R37's MDS with assessment reference date of 6/11/2024, he was admitted to the facility on [DATE]; had a BIMS score of 13 (13-15 Cognitively intact). The same MDS indicated R37 had a diagnosis of dementia and had a history of a stroke with weakness/paralysis on one side of his body. Occupational Therapy (OT) Evaluation and Plan of Treatment dated 5/01/2024 indicated R37 had impaired range of motion and strength of his left upper extremity and a contracture of his left elbow. The same evaluation revealed R37 was unable to functionally use his left upper extremity for activities of daily living (ADL). The same treatment plan indicated R37's goal was to improve function of his left arm. OT Discharge Summary dated 7/11/2024 revealed R37 was discharged from OT due to highest practical level had been achieved. Discharge recommendations included R37 continue with home exercise program, staff to complete passive range of motion of his left upper extremity. The same summary indicated R37's written program was left in his room for staff to complete. In review of R37's care plans, a home exercise program with passive range of motion was not included. CNA H was interviewed on 8/01/2024 at 1:37 PM and stated she was not aware of R37's home exercise program that was to be completed with staff. OT Q was interviewed on 8/01/2024 at 11:56 AM and stated a detailed range of motion plan for R37 was put in his room, prior to his discharge from OT on 7/11/24. OT Q stated he probably should have given a copy of R37's home exercise plan to the nurse manager. During an interview on 8/01/2024 at 12:17 PM, NM E stated when residents were discharged from therapy services, they were to give exercise plans to the nurse and the nurse was to update the care plan.

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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. 30337 Based on observation, interview, and record review, the facility failed to thoroughly assess, investigate and prevent falls, in one of three residents reviewed for falls (Resident #37), resulting in likelihood of additional falls and injuries. Findings include: Resident #37 (R37) On 7/30/2024 at 9:56 AM, R37 was observed lying in bed and stated he fell from his wheelchair recently attempting to reach for his call light and had scraped his back. In review of R37's Minimum Data Set (MDS) with assessment reference date of 6/11/2024, he was admitted at the facility on 2/29/2024; had a Brief Interview for Mental Status (BIMS, a short cognitive screener) score of 13 (13-15 Cognitively intact). The same MDS indicated R37 had a diagnosis of dementia and had a history of a stroke with weakness/paralysis on one side of his body. Incident Report dated 3/07/2024 at 9:45 AM revealed R37 fell in his room and called a family member for help. The same report revealed R37 was observed lying on his left side next to the bed in his room and stated to staff he was reaching for his cell phone with his right hand, the phone was on his bedside dresser on his left side. The same report indicated R37 was not able to grasp anything with his left hand. R37 reported he scraped his right shoulder and upper back on the bed. R37 could not reach his call light and was able to grab the cord of his cell phone to call his family for help after falling from his bed. R37's items were all moved to a bedside table on the right side of his bed, including his cell phone. Certified nurse assistants (CNA's) were all instructed to be sure R37's cell phone and call light were always placed on his right side. Post fall evaluation dated 3/07/24 at 9:45 AM included fall details, contributing factors, physical finds, medication review, vital signs, skin assessment and clinical comments. R37's risk for falls Care Plan dated 3/08/2024 instructed to ensure personal items were within reach and cell phone was placed on his right side. Incident Report dated 3/12/2024 at 4:16 PM indicated R37 was observed lying on the floor with his wheelchair behind him. The same report indicated the CNA had witnessed R37 sliding out of his wheelchair as she entered his room. In review of R37's medical record, there was no post fall evaluation completed after R37's fall on 3/12/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Occupational Therapy (OT) Evaluation and Plan of Treatment dated 5/01/2024 indicated R37 had impaired range of motion and strength of his left upper extremity and a contracture of his left elbow. The same evaluation revealed R37 was unable to functionally use his left upper extremity for activities of daily living (ADL). The same treatment plan indicated R37's goal was to improve function of his left arm.

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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. 38905 Based on observation, interview, and record review, the facility failed to store and prepare 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. Findings include: During a tour of the facility, starting at 9:40 AM on 7/30/24, an interview with Chef Manager U found that the facility does not cool much, but they do maintain a log for cooling. During a tour of the walk-in cooler, at 9:46 AM on 7/30/24, it was observed that three 1/8th pans of leftover breakfast puree items were found in the walk in cooler warm to the touch and covered in saran wrap. When asked about the items, Chef Manager U stated they don't typically keep those items. During a revisit to the kitchen, at 3:12 PM on 7/30/24, it was observed that a 1.5 gallon container of Corn chowder soup was found in the walk in cooler covered with saran wrap. A temperature of the soup was taken at this time and was found to be 107 F in the middle. An interview with [NAME] V and Dining Services Manager X found that food being cooled should get to 135 to 70 within 2 hours, When asked what time the soup was at 135 F? [NAME] V and Dining Services Manager X were unsure, but knew it was pulled from lunch today which was done around 12:30-12:45 PM. When asked what should be done with the soup, [NAME] V and Dining Services Manager X agreed to discard the soup. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During a tour of the cooks walk in cooler, at 10:04 AM on 7/30/24, it was found that packages of cooked shredded beef were thawing on an expediting rack under thawing portions of whole muscle raw animal product. When asked if this was the proper way to store raw animal product with ready to eat foods, Chef Manager U stated he would rearrange the items so that raw goes underneath, and placed the cooked shredded beef on the top of the rack. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the preparation cooler on the front serving line, at 3:16 PM on 7/30/24, it was observed that five raw hamburger patties were found stored on the top of the wire rack in a plastic bag. Next to and under the raw patties, were a container of grape jelly and a plastic bag of sliced turkey. According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,(b) Cooked READY-TO-EAT FOOD . During a tour of the health center pantry, at 10:41 AM on 7/30/24, it was observed that the single door freezer was found with a loose seal and gasket which is allowing humid air to accumulate ice inside the freezer. During a tour of the health center pantry, at 10:45 AM on 7/30/24, it was observed that the underside of the drink spouts found heavy black accumulation around the base of the juice dispensers. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.(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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview, and record review, the facility failed to ensure residents were screened for eligibility to receive pneumococcal vaccinations and receive vaccination if eligible for 2 (Resident #9 and #18) of 5 residents reviewed for vaccinations, resulting in the potential of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. Findings include: Resident #9 Review of an Admission Record revealed Resident #9 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes. Review of Resident #9's Immunization Record indicated that Resident #9 received a PCV13 (pneumococcal vaccination) on 5/2/2017. During an interview on 7/31/24 at 2:35 PM, Director of Nursing (DON) B reported that she was responsible for ensuring all residents were screened for vaccination eligibility and administration. DON B was unable to report when Resident #9 was last reviewed for pneumococcal vaccination eligibility. In a communication via email on 7/31/24 at 5:10 PM, DON B reported that .(Resident #9) was due for the PCV20 vaccination and was just offered the vaccination today by nurse manager . On 7/31/24, at 6:05 PM, the facility provided a copy of Resident #9's Patient Vaccination/Informed Consent/Declination form dated 7/31/24. The form indicated that Resident #9 was eligible to receive the PCV20 (pneumococcal vaccination) and Resident #9's guardian gave verbal consent for Resident #9 to receive the vaccination on 7/31/24. During a follow up interview on 8/01/24 at 8:44 AM, DON B reported that Resident #9's screening for the pneumococcal vaccination was missed by the facility. Resident #18 Review of an Admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease. Review of Resident #18's Immunization Record indicated that Resident #18 received the PPSV23 (pneumococcal vaccination) on 6/25/2019. During an interview on 7/31/24 at 2:35 PM, DON B was unable to report when Resident #18 was last reviewed for pneumococcal vaccination eligibility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24, at 6:04 PM, the facility provided a copy of Resident #18's Patient Vaccination/Informed Consent/Declination form dated 7/31/24. The form indicated that Resident #18 was eligible to receive the PCV20 and Resident #18's guardian gave verbal consent for Resident #18 to receive the PCV20 (pneumococcal vaccination) on 7/31/24. During an interview on 8/01/24 at 12:35 PM, DON B reported that Resident #18 had not been screened for pneumococcal vaccination eligibility until 7/31/24. DON B reported that Resident #18 was eligible to receive the PCV20. Review of the facility's Resident Pneumococcal Vaccination Policy dated January 2021 revealed, It is our policy to offer our residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations .