STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235312	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Big Rapids	725 W Fuller Big Rapids, MI 49307

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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 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** 28101 Based on observation, interview and record review, the facility failed to provide an appropriate size drinking cup to 1 resident (R16) of 1 Resident reviewed for reasonable accommodation of needs. Findings include: Review of R16's face sheet dated 8/19/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] she had diagnoses that included: Dementia, anxiety disorder, weakness and aphasia (difficulty in communication). R16 was not her own responsible party. R16 was observed in her room on 8/20/24 at 11:45 AM, R16 had a large plastic mug with a straw in it on her bedside table. R16's family member said they have talked to staff several times and reported at her care conferences that R16 does not have the strength to lift a mug that big. R16's family member reports for a week or two after voicing the concern the facility will provide a Styrofoam cup of water. R16's family member said she visits almost daily but will be taking a vacation soon and was worried R16 may get dehydrated as the resident cannot remember to alert staff of her needs. On 8/20/24 at 12:28 PM, R16's family member showed Unit Manager (UM) T that R16 had a large heavy plastic mug in her room and explained she had been asking for an appropriate size water cup for over a year. UM T said she just started last week, and she said she would look into it and address the concern. Review of R16's Kardex (caregiver care plan) dated 8/19/24 revealed. Please do not give me fluids in a big plastic mug. Please put my drinks in a Styrofoam cup or small coffee cup. The smaller cups are easier for me to hold by myself. Please offer me a drink at least once an hour per guardian.

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to investigate and report an allegation of misappropriation to the state survey agency for 1 of 3 residents (R20) reviewed for abuse and misappropriation, resulting in the potential for abuse and misappropriation to go undetected, underreported, and not investigated. Findings include: A review of R20's Admission Record, dated 8/20/24, revealed R20 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R20's Admission Record revealed multiple diagnoses that included dementia and depression. A review of R20's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 5/15/24, revealed R20 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R20 was cognitively intact. During an interview on 08/19/24 at 10:45 AM, R20 stated her cell phone came up missing about three months ago (two weeks after she was admitted). She stated the facility looked everywhere for it but could not find it. R20 also stated about two months ago she had a baggy with 7 quarters in it that came up missing. She stated her cell phone and her quarters were not left out and were out of sight. R20 also stated she was told that the facility does not replace missing money. R20 denied anyone could have come in to visit her and took her cell phone or quarters with them. She stated that she reported to the highest levels that her cell phone was missing. -A review of R20's progress notes, dated 5/8/24 to 8/20/24 revealed the following: - Nursing Progress Note, dated 5/9/24, revealed, Guardian notified via voice message that resident does have a telephone in her room. * No mention that R20 complained that her cell phone and/or money was missing. A review of R20's Resident Personal Belongings Inventory, dated 5/8/24, revealed she had a cell phone, but no cash when she was admitted to the facility. Two people signed the form verifying that she had the cell phone, but no cash when she was admitted to the facility. On 08/20/24 at 01:05 PM, all concerns forms and incident reports (including any follow-up/investigations/supporting documentation, if applicable) for R20 were requested from the Nursing Home Administrator (NHA). During an interview on 08/20/24 at 04:50 PM, the NHA stated they did not have any concern forms or incident reports for R20. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview on 08/21/24 at 08:35 AM, R20 stated she reported her missing cell phone to floor staff, the social worker, and administration. She stated she also reported her missing cell phone to someone from administration two days ago. However, R20 could not remember anyone's names and could not describe the administration person she reported the missing cell phone to two days ago except he was not tall, but not short and he was younger, but not the person I spoke to three months ago. During a second interview on 08/21/24 at 10:15 AM, the NHA stated that he was not aware R20 had made the allegations that her cell phone and quarters were missing. The surveyor reported R20's allegations of her missing cell phone and quarters to the NHA. He stated he would follow-up with her. The surveyor requested that the NHA follow up with them on what the facility is doing and the process that he is following (i.e., start investigation the allegation, reporting the allegation to the state survey agency, etc.). During a third interview on 08/21/24 at 11:15 AM, the NHA stated he spoke with R20. He stated R20 verified that her cell phone and 7 quarters were missing. The NHA stated the plan was he was going to fill out a concern form for R20 about her missing cell phone and money. He stated they are going to search the laundry for the cell phone and continue to look for it. The NHA stated if they cannot find R20's cell phone, then he will start a 5-Day Investigation (report the allegations to the state survey agency and start an investigation). The NHA was asked how long would he look for R20's cell phone before he starts an investigation? He stated if they did not find R20's cell phone by tomorrow morning (8/22/24), then he will start his 5-Day Investigation. A review of the state reporting system for facility reported incidents (FRI's) on 8/21/24 at 03:15 PM (5 hours after R20's allegation was reported to the NHA), failed to reveal that the facility had reported R20's allegation of a missing cell phone and money. In addition, as of the completion of the survey and exit from the facility, the facility failed to provide any documentation that they had initiated an investigation (except for the NHA's statement that he had interviewed R20). A review of the facility's Abuse, Neglect and Exploitation policy, reviewed/revised 6/24, revealed, A. The facility will implement the following . 2. Reporting of all alleged violations to the state agency, adult protective services and all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to provide care for 1 (Resident #8) of 2 residents reviewed for Activities of Daily Living (ADL) care. Findings include: Resident #8 (R8) Review of a Face Sheet revealed R8 originally admitted to the facility on [DATE] with pertinent diagnoses of multiple sclerosis, cognitive communication deficit (not interviewable), and contractures. In an interview on 8/19/24 at 2:20 PM, the Guardian of R8 reported he was not being provided with oral care often and the staff are not using the [Brand name of oral moisturizer] gel she provided them with to keep his mouth moist. The Guardian reported she visits every other day and will observe his mouth with caked, dried on secretions that could be avoided if he had routine care with the gel. The Guardian also had concerns R8 was in bed most of the day and not up in his electric wheelchair. R8 enjoys being up in his wheelchair and she had expressed her concerns with the staff. During an observation and an interview on 8/19/24 at 2:42 PM, Certified Nursing Assistant (CNA) I reported she tries to clean R8's mouth every time she comes into the room and showed where his oral swabs were and his oral [Brand name of oral moisturizer] products were. She reported she provided oral care around 1:30 PM when she last seen him. The resident was lying in bed with his mouth wide open and tongue was dry with white strands of dried secretions. His tongue looked dry as well as his lips. CNA I then said she tries to do oral care once a day and left the room without doing oral care. During an observation and an interview on 8/20/24 at 1:55 PM, CNA J and CNA K were in R8's room to reposition him, and his mouth was open and dry. Asked when he was last provided oral care and the CNAs did not know. When asked if his mouth was dry, CNA J took a mouth swab, applied the [Brand name of oral moisturizer] product, and quickly swabbed the open area of his mouth and his tongue. When asked why she did not swab the roof of his mouth or his gums, she grabbed another swab and cleaned the roof of his mouth which had a large amount of dried secretions removed. She then used another swab and cleansed/moistened his gums. In an interview on 8/20/24 at 2:04 PM, CNA L reported she was R8's primary caregiver and said she tries to do oral care on him at least 3 times a shift and she works 12-hour shifts. She then reported she tries to do oral care every time she provides care for him and will sometimes suction his mouth if needed. She reported R8 was not up in his wheelchair this day because she had another aide temporarily care for him and thought they would get him up. Review of the Kardex for R8 revealed: -ORAL CARE AM/HS (morning and night) ROUTINE: (brush teeth, cleanse tongue, clean gums with toothette using [Brand name of oral moisturizer]). Assistance Needed: dependent. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- I require total assistance with personal hygiene care. Mouth care should be completed every 4 hours with moistened toothette. -Provide with Routine Oral Care with soft brissle (sic) toothbrush and toothpaste or [Brand name of oral moisturizer] gel twice daily. - Swab my mouth with toothlette every two hours or more, if necessary, as I allow. - Swab oral cavity with ORAL MOISTURIZER [Brand name of oral moisturizer] mother supplies at bed side. (sic) -I would like to be in my high back wheelchair twice a day. Once in the morning and also in the afternoon. Review of a Task List document titled Swab oral cavity with ORAL MOISTURIZER [Brand name of oral moisturizer] mother supplies at bed side retrieved on 8/21/24 for R8 with a 30 day look back revealed most days R8 is documented as receiving oral care 2-3 times a day. In an interview on 8/21/24 at 12:00 PM, Licensed Practical Nurse/Unit Manager (UM) F reported they do provide training for oral care to their staff and residents are to get oral care at least every 2 hours.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interviews, and record review, the facility failed to provide meaningful activities for 2 Residents (R7 and R16) of 2 residents sampled. Findings included: R7 Review of R7's face sheet dated 8/20/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Dementia, Alzheimer's Disease, major depressive disorder, anxiety disorder and difficulty in walking. R7 was not her own responsible party. R7 was observed sleeping on 8/19/24 at 11:05 AM. R7 was observed sleeping on 8/20/24 at 1:15 PM. During an interview with Certified Nurse Aides (CNA) O and CNA P on 8/20/24 at 1:17 PM, they explained R7 normally sleeps all day, she rarely eats breakfast or lunch. They do attempt to wake her up for breakfast and lunch, but she rarely eats. They were aware she generally wakes up a 5:00 PM. They did not know what her activity or food preferences were as they rarely see her awake long enough to do these activities. During an interview with the Activity Director (AD) Q on 8/21/24 at 10:07 AM. AD Q said she is the only employee in the Activity department. AD Q said she currently has 2 volunteers that work only morning hours and do limited activities with residents. AD Q was not aware R7's normal routine was to sleep during the day and is most alert at night. AD Q was not able to locate any documentation that showed R7 was provided any activities over the last 30 days and currently had no ability to assign any staff to provide activities that were meaningful to this resident during her normal wake hours or on weekends. Review of R7's care plan revealed, I am here for long term care and will be invited to participate in activity program, initiated 10/29/21. Short term goal revealed, I will participate in 1:1 activity 3 day per week. Interventions included, I will enjoy a visit form activity staff. I will enjoy taking a walk within the facility. My life occupation was being a waitress and bartender. R16 Review of R16's face sheet dated 8/19/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] had diagnoses that included: Dementia, anxiety disorder, weakness and aphasia (difficulty in communication). R16 was not her own responsible party. R16 was observed sleeping in bed on 8/21/24 at 8:45 AM. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the AD Q on 8/21/24 at 10:07 AM, AD Q said R16 was care planned for activities, but she was down one volunteer and had no documentation to show R16 had received any activities in the last 30 days. During an interview on 8/21/24 at 3:00 PM, R16's family member expressed concern that the facility lacked activities for R16. R16's family member comes in generally 6 days a week. The family member was concerned that when she was not able to be there during vacations or on the weekends, R16 was not having anyone that would read to her or spend quality time with her. Review of R16's care plan dated 1/17/23 revealed, I am here for long term care and will be invited to participate in the activity program. Short term goal included, I will participate in group activities of interest. I enjoy arts and crafts and bingo.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview, and record review, the facility failed to apply hand splints for 1 (Resident #8) of 1 resident reviewed for contractures. Findings include: Resident #8 (R8) Review of a Face Sheet revealed R8 originally admitted to the facility on [DATE] with pertinent diagnoses of multiple sclerosis, cognitive communication deficit, and contractures. In an interview on 8/19/24 at 2:20 PM, the Guardian of R8 reported he was not wearing his braces/splints on both hands anymore and when he did wear them, the staff was not applying them correctly and the straps would rub his knuckles really hard. During an observation and an interview on 8/19/24 at 2:42 PM, Certified Nursing Assistant (CNA) I repositioned R8 who was laying in bed hugging a couple of pillows. CNA I reported he gets skin breakdown on the inside of his elbows and the pillows help prevent that. He did not have any splints on his contracted hands. When queried about splints for his hand contractures, CNA I reported his splints are in the dresser drawer and left the room without applying the splints. Review of the Splints On? Task List documentation revealed on 8/19/24, R8 was documented as having the hand splints on at 2:31 PM. Review of the Kardex for R8 revealed: - Right hand splint to be on for 3 hours and off for 2 hours. - Splints On for 3 hours, off for 2 hours During an observation on 8/20/24 at 8:45 AM, R8 was observed in bed with no splints on his hands. During an observation on 8/20/24 at 11:26 PM, R8 was observed in bed with no splints on his hands. During an observation and an interview on 8/20/24 at 1:55 PM, CNA J and CNA K were in R8's room to reposition him and he did not have hand splints on. CNA K reported he thought the hand splints were in the dresser drawer. Both CNAs reported they were not R8's primary aides and were helping but did not know the schedule for R8's placement of splints. Review of the Splints On? Task List documentation revealed on 8/20/24 R8 had them on at 12:33 PM. In an interview on 8/20/24 at 2:04 PM, CNA L reported she was R8's primary caregiver this day and was not aware of any braces or splints that needed to be applied on his hands. We went to R8's room and observed two splints in the dresser drawer. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Occupational Therapy Discharge summary dated 11/2/21 for R8 revealed: After cleaning with wash cloth & drying the hand put on splint in [right] hand. In an interview on 8/20/24 at 3:00 PM, Physical Therapy Director (PT) M reported R8 has had some restorative therapy for contractures in his arms and is also to have splints in his hands for his contractures. In an interview on 8/21/24 at 12:00 PM, Licensed Practical Nurse/Unit Manager (UM) F reported according to the Kardex, R8 is to be on a schedule to have his splints off and on. Review of the Splints On? Task List documentation revealed on 8/19/24 R8 had them documented as on 7 times. On 8/20/24, R8 was documented as having the hand splints on twice and documented as refused 3 times. The splint application times do not reflect the 3 hours on and 2 hours off scheduling. Review of the Physician Orders for R8 revealed no orders for splints.

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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. 30120 Based on observation, interview, and record review, the facility failed to ensure expired medications were not in 1 of 2 medication carts inspected (Northwest Medication Cart) and failed to secure 1 of 4 medication carts (Southwest Medication cart). Findings include: During an inspection of the Northwest Medication Cart with Licensed Practical Nurse (LPN) A and the Director of Nursing (DON) on 8/19/24 at 5:15 PM, the following observations were made: - An opened 8 fluid ounce bottle of Senna Syrup (a laxative) was observed to have an expiration date of 1/24. - An opened bottle of a multivitamin was observed to have an expiration date of 3/24. - LPN A and the DON verified these findings. During an observation on 8/21/24 at 8:25 AM, the Southwest Medication Cart was observed in the hallway, unlocked, and unattended. There were not any staff within sight of the medication cart. During an interview on 8/21/24 at 8:30 AM, Registered Nurse (RN) E (the nurse assigned to the Southwest Medication Cart) stated she did not see an issue with leaving the medication cart unlocked because I was only two rooms away [administering medications]. She stated she normally locks her medication cart before she walks away from it. She then indicated that leaving the medication cart unlocked and unattended was not an issue because she was only two rooms away from it even though she could not see the cart from inside the resident's room. During an observation on 8/21/24 at 8:40 AM, the Southwest Medication Cart was observed to be in the hallway, unlocked, and unattended. RN E had been observed preparing medications for a resident and had walked away from the medication cart to administer those medications just prior to the observation. During an interview on 08/21/24 at 11:15 AM, LPN F stated the nurses are supposed to lock their medication carts before they walk away from them. She stated the medication carts should not be left unlocked if the nurse is not at the medication cart. During an interview on 08/21/24 at 1:32 PM, RN B stated the nurse is supposed to lock the medication cart when they are not at the medication cart. She stated they are supposed to lock the cart in order to secure the medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 2:06 PM, LPN D stated she is supposed to lock her medication cart when she walks away from it. She stated she does this to protect the medications in it from people just taking them. LPN D stated she had left her medication cart unlocked twice that morning when she went to give residents their medication. You caught me. A review of the facility's Medication Storage In The Facility policy and procedure, dated June 2019, revealed, Mediations and biologicals are stored safely, securely, and properly . The medication supply is accessible only to licensed personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 30120 Based on observation, interview, and record review, the facility failed to safeguard the confidentiality of medical records for 2 of 60 facility residents [R34 and R46), resulting in the potential for unauthorized access to resident medical records and the potential for the loss of resident privacy and confidentiality of their personal health information. Findings include: R46 During an observation on 08/21/24 at 8:25 AM, the computer screen on top of the Southwest Medication Cart was observed open to R46's electronic Medication Administration Record, (e-MAR). R46's personal and health identifying information (i.e., picture, name, room number, physician's name, allergies, recent vital signs, code status, special instructions for medication administration) and medications were visible to anyone walking by the medication cart. No staff were visible within sight of the medication cart. During an interview on 8/21/24 at 8:30 AM, Registered Nurse (RN) E (the nurse assigned to the Southwest Medication Cart) stated she did not see an issue with leaving the computer screen open to R46's e-MAR because I was only two rooms away [administering medications]. She stated she normally closes the computer screen before she walks away from the medication cart. She then indicated that leaving the computer screen open to R46's e-MAR was not an issue because she was only two rooms away from it even though she could not see the cart from inside the resident's room. R34 During an observation on 08/21/24 at 8:40 AM, the computer screen on top of the Southwest Medication Cart was observed open to R34's electronic Medication Administration Record, (e-MAR). R34's personal and health identifying information (i.e., picture, name, room number, physician's name, allergies, recent vital signs, code status, special instructions for medication administration) and medications were visible to anyone walking by the medication cart. During an interview on 08/21/24 at 11:15 AM, LPN F stated the nurses are supposed to close the computer screens before they walk away from the medication carts. She stated the computer screens should not be left open when they are not at the medication carts. During an interview on 08/21/24 at 1:32 PM, RN B stated the nurses are supposed to close the computer screens when they are not at the medication carts. She stated they are supposed close the computer screens because of the Health Insurance Privacy and Portability Act (HIPPA) which protects the confidentiality and privacy of residents personal health information. (continued on next page)

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	235312	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Big Rapids	725 W Fuller Big Rapids, MI 49307

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 2:06 PM, LPN D stated the nurses are supposed to close the computer screens when they walk away from the medication carts. She stated she closes it to protect the residents' health information. LPN D further stated she had left her computer screen open and walked away from her medication cart twice this morning. You caught me. A review of the facility's HIPPA Security Measures policy, dated 11/01/2023, revealed, It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and/or records that are in electronic format . All workstations that access EPHI (electronic protected health information) will have restricted access .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record review, the facility failed to provide collaborative hospice care for 2 Residents (R4 and R7) of 2 residents reviewed for hospice care. Findings included: Review of R4's face sheet dated 8/21/24 revealed, she was a [AGE] year-old female that admitted to the facility on [DATE] and had diagnoses that included: Parkinson's disease and adult failure to thrive. She was not her own responsible party. R4 was observed on 8/21/24 at 8:49 PM sitting on the edge of her bed with her head down on the mattress on her right side. R4 had vomited on her shirt and her bed. Registered Nurse (RN) E, Certified Nurse Aides (CNA) Q and (CNA) R came in to provide care. They were all aware R4 was in hospice care. None of them were aware of the last time the hospice staff were in to provide service and had no idea of when hospice was scheduled to see R4 again. RN E said at one point hospice kept their schedules in a book at the nursing station. RN E looked at all the books at the nursing station and could not locate any hospice information for any residents on her unit. During an interview with RN N on 8/21/24 at 11:55 AM, she confirmed the facility did not have schedules or documentation the day of hospice service for all of the residents in hospice care. RN N said she had contacted hospice services yesterday and was working with them to get monthly schedules. RN N said all hospice staff are to be charting in the residents' medical records. RN N said they are now working with hospice to improve communication and scheduling. Review of R4's progress notes on 8/21/24 revealed the last progress note in R4's electronic medical record (EMR) was dated 8/21/24 at 9:24 AM, Alert Note. Note Text: Impaired Skin integrity was documented. Resident refused shower for facility staff, prefers hospice to do her showers. The last hospice progress notes in R4's EMR was 8/12/24 at 13:29 (1:29 PM), MSW (Masters Social Worker saw patient for social visit. There was no indication that any hospice staff saw R4 or provided any services between 8/21/24 at 9:24 AM to 8/12/24 at 1:29 PM. It was not clear that R4 had tolerated any showers during this time frame. R7 Review of R7's face sheet dated 8/20/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: Dementia, Alzheimer's Disease, major depressive disorder, anxiety disorder and difficulty in walking. R7 was not her own responsible party. R7 was observed sleeping on 8/19/24 at 11:05 AM. R7 was observed sleeping on 8/20/24 at 1:15 PM. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nurse Aides (CNA) O and CNA P on 8/20/24 at 1:17 PM, they explained R7 normally sleeps all day, she rarely eats breakfast or lunch. They do attempt to wake her up for breakfast and lunch, but she rarely eats. They were aware she generally wakes up a 5:00 PM. They did not know what her activity or food preferences were as they rarely see her awake long enough to do these activities. During an interview with Social Worker (SW) S on 8/20/24 at 1:20 PM, the hospice staff schedules for R7 were discussed. SW S could not verify what the hospice schedule was for R7, and she was informed that the current facility staff were not able to locate R7's hospice worker schedule. SW S could not verify hospice was aware of R7's history of sleeping during the day and awake at nighttime. During an interview with RN N on 8/21/24 at 11:55 AM, she confirmed the facility did not have any hospice schedules or documentation indicating the day hospice services were provided prior to yesterday (8/20/24) for all residents receiving hospice services. RN N said she had contacted hospice services yesterday and was working with them to get monthly schedules. RN N said all hospice staff are to be charting in the residents' medical records. RN N said they are now working with hospice to improve communication and scheduling. RN N said they met with hospice and family yesterday and started to make care plan changes. RN N said the hospice nurse was in this morning. RN N said they did not inform hospice of R7's sleep cycle because they had just started a sleep cycle assessment, therefore R7's hospice plan was still set up for care during the daytime. RN N said the only indication in R7's current care plan that R7 had a history of being awake at nights was that she had been a bartender. Review of R7's progress notes revealed that R7's last progress note in her EMR was dated 8/8/24 at 20:53 (8:53 PM). Visit today was a face to face and occurred with visual and audio [Name of hospice doctor] and writer reviewed PT's (patients) declines over the last 2 months. During meeting PT refused to talk or do anything doctor asked. PT has been sleeping more, talking and responding less. PT had a fall on 6/22 that caused bruising on left hips and ribs. Pt use to AMB (ambulate/walk) with walker but now PT refuses to get out of bed but when writer or staff take her to shower room she will sit on walker bench seat. PT is down to 81.5 LBS (pounds) a 3.44% total weight loss in 2 months. The last 14 days PT refused meals 18 times, ate 0% 5 times and averaged 50 % the rest of the meals served. PT BMI is at 19.6 has increased leading to writer making PRN (as needed) Tramadol (pain medication) to scheduled BID (twice a day) with PRN (as needed) available for breakthrough pain. PT's (patients) daughter also stated that she has seen a huge decline in the last 3 months. Last year took PT (patient) to the fair but with her recent declines daughter was scared to try. No new medications changes at this time. No other concerns from facility staff at this time. There were no progress notes located in R7's progress note section to indicate any hospice services were provided since 8/8/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on observation, interview, and record review, the facility failed to clean a glucometer per the manufacturer's instructions for 2 of 2 residents (R28 and R37) reviewed for blood glucose testing, resulting in the potential for the spread of infection and disease. Findings include: R37 A review of R37's Admission Record, dated 8/21/24, revealed R37 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R37's Admission Record revealed multiple diagnoses that included diabetes. During an observation on 8/19/24 at 4:50 PM, Licensed Practical Nurse (LPN) A was observed cleaning the glucometer machine with a 70% isopropyl alcohol prep pad after checking R37's blood sugar level. LPN A cleaned the machine by quickly swiping it with the alcohol pad. LPN A stated an alcohol prep pad can be used to properly clean and sanitize their glucometer machines. R28 A review of R28's Admission Record, dated 8/21/24, revealed R28 was a [AGE] year-old resident admitted to the facility on [DATE] and readmitted on [DATE]. In addition, R28's Admission Record revealed multiple diagnoses that included dementia. During an observation on 8/20/24 at 8:10 AM, LPN B was observed cleaning the glucometer machine by quickly swiping it with a 70% isopropyl alcohol prep pad after checking R28's blood sugar level. LPN B stated an alcohol prep pad can be used to properly clean and sanitize their glucometer machines. During a second interview on 8/20/24 at 4:35 PM, LPN A stated staff can clean the glucometers with either an alcohol pad (70% isopropyl alcohol) or a [Brand name] Germicidal Bleach Wipe which kills multiple types of spores and viruses, including Hepatitis viruses and HIV. LPN A stated the alcohol pads and bleach wipes can be used interchangeably to clean and sanitize the glucometer machines. During an interview on 8/21/24 at 8:25 AM, LPN D stated the nurses are only supposed to use [Brand name] Germicidal Bleach Wipes to clean and sanitize the glucometers. She stated they are not supposed to use the alcohol pads to clean the machines. During an interview on 8/21/24 at 8:35 AM, Registered Nurse (RN) E stated she only uses the alcohol pads to clean and sanitize the glucometer machines. During an interview on 8/21/24 at 10:38 AM, [NAME] President of Clinical Operations (VPCO) N and Unit Manager F stated staff should not be cleaning the glucometer machines with alcohol pads. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Cleaning and Disinfection of Resident-Care Equipment policy, revised 8/24, revealed, Resident-care equipment can be a source of indirect transmission of pathogens (i.e. bacteria and viruses). Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC (Centers for Disease Control and Prevention) recommendations to break the chain of infection . Use only EPA (Environmental Protection Agency)-registered disinfectants with kill claims for the common organisms found in the facility . Follow manufacturer recommendations for cleaning equipment. A review of the manufacturer's operator and in-service manual for the glucometer machines that the facility uses, dated 2023, revealed only specific disinfecting wipes that are EPA approved and contain bleach and/or a combination of alcohol and another combination of germicidal and bactericidal ingredients (e.g., a quaternary solution) are to be used to clean their glucometer machines. The manufacturer's instructions also indicate that other EPA Registered wipes may be used besides the recommended ones, however they could affect the performance of the machines. The manufacturer's instructions also state that the proper contact time (amount of time the machine must remain wet from the wipe in order to effectively sanitize and disinfect the machine) for the type of wipe used must be followed. A review of the EPA's Registered Anatomic Products Effective Against Bloodborne Pathogens, dated 8/22/24, revealed isopropyl alcohol was only effective against Human Immunodeficiency Virus (HIV), Hepatitis B, and Hepatitis C (viruses common to nursing home facilities) when used in a combination product with another ingredient (e.g., quaternary ammonium). In addition, the combination products that had isopropyl alcohol as an ingredient all had contact times (the amount of time the surface needed to stay wet in order to sanitize and disinfect it) ranging from 0.5 minutes to 10 minutes- not the quick amount of time that the glucometers were dry by with a quick swipe of an alcohol pad). A review of the CDC's Infection Control Chemical Disinfectants Guideline, dated 11/28/23, revealed, Alcohols are not recommended for sterilizing medical and surgical materials principally because they lack sporicidal action and they cannot penetrate protein-rich materials . They also evaporate rapidly, making extended exposure time difficult to achieve unless the items are immersed . A review of the CDC's Injection Safety Considerations for Blood Glucose Monitoring and Insulin Administration web page, dated 8/7/24, revealed, Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions . Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place . If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents . If healthcare providers use blood glucose testing or insulin administration devices on more than one patient, equipment and supplies may become contaminated. Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, HIV, and other infections