STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235367	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norlite Nursing Center	701 Homestead St Marquette, MI 49855

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40383 Based on observation, interview, and record review, the facility failed to provide a dignified dining experience in their Dining Room (DR) by standing over seated residents while assisting with feeding and failing to serve all residents at the same table together. This deficient practice had the potential to affect all residents dining in the main dining room. Findings include: During the lunch meal service on 11/19/24 at 12:30 PM, approximately 30 residents were observed in the DR. Six of the seven tables with multiple residents seated at them each were partially served. Some residents at each of the six tables were eating while other residents sitting at the tables did not have their meals. One table had one resident eating while three residents and several visitors at the same table were waiting. Approximately 20 minutes later at 12:50 PM, two of the three residents waiting at this table were served while one resident continued to wait. At 1:05 PM, the last resident at this table was served. During an interview on 11/19/24 at approximately 1:10 PM, the visitors at this table who had visited with their family member during the meal service acknowledged the last resident to be served at this table had been sitting and waiting with them before 12:30 PM. During the lunch meal observation on 11/19/24 at 12:39 PM, staff member L assisting with the serving of the meals told one resident after serving the first tray at a round table, Yes you are all going to get lunch. Thanks for your patience. The resident replied, I am just waiting and watching. I hope they bring me something pretty soon. At 12:47 PM the resident was served, but the other two residents waiting at the table were not served and watched the other residents at the table eat. One resident at the table moved the tablecloth and laid her forehead on the edge of the table to rest. At 12:56 PM she was served, and the last resident at the table was served at 12:57 PM. During this lunch meal observation of 11/19/24 at 12:45 PM, Resident #41 said he had been waiting quite a while. He stated, I was five minutes late coming in and now I will have to wait longer. Both of his table mates were eating. He sat there and dozed off while his other two table mates continued eating until 12:53 PM when his tray arrived. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the breakfast meal observation on 11/20/24 at 7:06 AM, several residents were in the DR awaiting the meal. At 7:43 AM, four residents were at the round table near the service area and the first resident was served. At 7:57 AM, the next table mate at this table was served. At 7:58 AM the resident who was observed in the dining room at 7:06 was served, and at 8:01 AM the last member of the table was served. During this time multiple staff members were assisting in the dining room and serving others at different tables in no particular order. One table had two residents eating by 7:48 AM and others were waiting. At 7:55 AM, five residents were served at this table and one last resident continued to wait for his breakfast. By 8:09 AM, two of the residents at the table had finished and were leaving but the final resident continued to wait. At 8:11 AM, the last resident at this table was served. This breakfast observation of 11/20/24 at 8:00 AM included five tables with multiple residents and four of those tables had been partially served while the others watched them eat and wait. During the breakfast observation on 11/20/24 at 8:34 AM, two dependent residents were being fed by staff who were standing over the residents while the residents were seated. Registered Nurse (RN) F was consulted and stated, No they should not be standing. Sitting is more personable. On 11/20/24 at 8:52 AM, staff member I who had been observed assisting residents while standing over residents, stated, We should sit (when feeding). During an interview on 11/20/24 at 2:58 PM, Certified Dietary Manager (CDM) stated the standard of practice was, We should serve the same table at the same time. On 11/20/24 at 8:55 AM, the Director of Nursing (DON) stated the expectation was staff should be seated while feeding the residents. The DON provided the training program for assisting and feeding residents but positioning while feeding or tray distribution per table was not found in this document. No further policies concerning these issues were provided prior to the conclusion of the survey.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 Based on interview, and record review, the facility failed to ensure adequate nutritional assessment, and interventions for one Resident (#63) of one resident reviewed for significant weight loss. Findings include: Resident #63 (R63): On 11/19/24 at 8:03 AM, R63 said they had been losing weight. R63 denied issues with their teeth or swallowing difficulties that could affect their eating habits. R63 stated they had spoken with the Certified Dietary Manager (CDM) to discuss food preferences, but did not have much hope that the food wood change to R63's liking. Review of R63 Electronic Medical Record (EMR) indicated R63 was admitted to the facility on [DATE]. On 10/24/24, a Brief Interview for Mental Status (BIMS) assessment was completed for R63, resulting in a score of 13 out of 15, indicating R63 was cognitively intact. Review of a progress note dated 11/15/24 at 1:13 PM, CDM note read in part [R63] has experienced an 11# or 9% weight loss over the course of one month . [R63] told the writer she didn't know how to fill out a menu so dietary could honor her meal preferences. So, the writer sat with her and filled out a few days so she would get the idea of how it worked. [R63] had complaints of cold scrambled eggs; stating: I love scrambled eggs but they're always cold . [R63] will be referred to the RD [Registered Dietician] per significant weight policy . R63's diet order was changed to a regular diet on 11/15/24. The care plan was not updated to reflect nutritional interventions based on the order change. While conducting a phone interview with the RD on 11/20/24 at 8:47, the RD said she had not been made aware of R63's weight loss. The RD said the process for referral for evaluation was for the facility staff to write the resident on the RD referral list located in the facility. The RD stated someone from the facility should call her via phone if the resident was experiencing nutritional concerns of significant weight loss. The RD stated she would look at R63 now that she was aware of the resident's significant weight loss. On 11/20/24 at 10:15 AM, during an interview, the Director of Nursing (DON) stated if a significant weight loss was identified they would call the RD. The DON stated that it would be any resident that would have a 5% or greater weight loss in a month, or 10% or greater in 6 months. A progress note dated 11/20/24 by the RD: RD referral for wt. [weight] loss. I spoke with the State Surveyor over the phone. She gave me a brief report on [R63] and made me aware of wt. loss. Diet: Regular. Wt.: 113 lbs. on 11/14/24. Previous wts (weights).: 124 lbs. on 10/10/24 --- 1 month ago (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	130 lbs. on 7/18/24 -- 4 months ago Wt. is down 11 lbs. (8.8%) in 1 month. This is considered significant wt. loss in the look back period. I see that the Dietary Manager has intervened and spoke with her to update food preferences . Intake has been 25-50% of meals . The doctor was made aware, and her diet was liberalized from Consistent Carbohydrate, No Added Salt to Regular. I agree with that, but because of her minimal intake at meals, I would recommend (Name Brand Meal Supplement) once a day . [R63's] wt. did go down 5 lbs. in ~1 week, so I also asked for a re-weight to ensure we have an accurate wt . On 11/21/24 09:11 AM, while conducting a follow up interview with DON, the DON stated the process for calling the RD would start with a message on their facility messaging system to check with the team to see if this resident was thought to have a significant weight loss. The DON stated they would reweigh the resident to make certain there was no user error. The DON could not state why R63 had not been re-weighed or why the RD was not notified timely of R63's significant weight loss. The facility's Nutritional Assessment policy dated 12/9/14 read in part . K. Dietician will be notified of any dietary concerns . M. More frequent assessments of resident nutritional status will be at the discretion of the Dietician and Food Service Director based on resident condition and care planned interventions

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to ensure a change in condition was assessed and monitored by the attending physician for one Resident (#22) of 19 sampled residents. Findings include: Resident #22 (R22) Review of R22's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including acute kidney failure and retention of urine. Review of R22's most recent Minimum Data Set (MDS) assessment, dated 9/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicative of intact cognition. On 11/21/24 at 8:02 AM, R22 was observed sitting in a wheelchair at a dining room table, slowly propelling forward and backward with his legs. When asked why R22 preferred the continued rocking motion, he stated, My leg still aches . I had a blood clot not too long ago. Review of R22's EMR revealed the following progress notes: 1. 2/27/24 at 14:00 [2:00 PM] written by Licensed Practical Nurse (LPN) G: Resident has 3+ [moderate] pitting edema to BLE [bilateral lower extremities]; L [left] lower leg is pink and warm to touch; [physician] paged; no return call from Dr. [Doctor] prior to leaving for day; passed information to 400 [unit] charge nurse . 2. 2/27/24 at 16:55 [4:55 PM]: [Physician] updated on resident weight increase and BLE 3+ pitting edema. Residents left lower leg is red and warm to the touch. [Physician] to come to facility to assess resident . R22's EMR revealed no physician assessment following identification of bilateral pitting edema of the lower extremities, as well as warmth and redness to the left lower leg. On 11/21/24 at approximately 10:00 AM, an interview was conducted with LPN G who verified she assessed R22 on 2/27/24 and identified the acute change in condition, which included a swollen, red, and warm left leg. LPN G stated she communicated concerns for a deep vein thrombosis [blood clot] to the charge nurse who was responsible for contacting the provider. LPN G stated, I didn't know [R22] was never evaluated by the physician. If I would have known that I would have followed up with the doctor myself .that's unacceptable. Review of R22's progress notes revealed he was transferred to the emergency room (ED) via ambulance on 3/4/24 for an unrelated concern: During routine shower CNA [certified nursing assistant] notified staff of swelling to resident's [R22's] penis . new order to send resident to ER for further evaluation and treatment . Review of a progress note dated 3/4/24 at 21:51 [9:51 PM] read, in part: (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident [R22] returned to [facility] with a diagnosis of L DVT [left leg deep vein thrombosis], paraphimosis (trapped foreskin) , and cystitis (bladder infection) . Review of the Radiology Report from the acute care hospital dated 3/4/24 read, in part: .nonocclusive (no blockage) thrombus [clot] noted in the left popliteal (vessel behind knee) vein and left peroneal (lower leg) vein . concerning for acute nonocclusive DVT . On 11/21/24 at 8:49 AM an interview was conducted with the Director of Nursing (DON) and Clinical Consultant/Registered Nurse (RN) M who confirmed R22 was never evaluated by the physician following identification of clinical symptoms which correlated with a possible blood clot. The DON stated the clinical expectations following a change in condition included notification of the physician, monitoring the resident, and ensuring follow-up by the provider. Both the DON and RN M stated the diagnosis of a DVT 6 days after initial identification of signs and symptoms was untimely. Review of facility policy titled, Change in Condition, Acute revised 12/10/14 read, in part: .Observations, subjective information from the resident, and clinical signs will be documented in the Nursing Notes and on the Change of Condition form .after the physician is notified .the completed notification will be forwarded to the RN Supervisor file [at] the Nursing Station . No Change in Condition form for R22 was located following identification of signs/symptoms of a DVT on 2/27/24. Review of The Clinical Diagnosis of Deep Venous Thrombosis Integrating Incidence, Risk Factors, and Symptoms and Signs, published by the Archives of Internal Medicine (https://doi.org/10.1001/archinte.158.21.2315), read, in part: Typical symptoms of DVT are pain, warmth, redness, and swelling of the lower extremity . Accurate and timely diagnosis and treatment of DVT are essential. Early treatment of DVT with anticoagulants has been demonstrated to (1) reduce the incidence of pulmonary embolism and its associated mortality, (2) relieve acute symptoms in the leg, and (3) prevent extension of DVT from calf veins to more proximal veins .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49310 Based on observation, interview, and record review, the facility failed to ensure one medication cart remained locked when unattended of four medication carts reviewed, and failed to discard two expired glucose meter control solutions of six control solutions reviewed. This deficient practice resulted in the potential for misappropriation of medications for the nine residents on the 500 unit, and the potential for inaccurate blood glucose readings for six residents receiving blood glucose testing. Findings include: On [DATE] at 3:42 p.m. and [DATE] at 1:53 p.m., the medication cart on the 500 unit was unlocked and unattended. The Director of Nursing (DON) was questioned on [DATE] at 8:05 a.m. regarding the expectation for securing the medication carts. The DON said the expectation is for medication carts to be kept locked when not in use and for nurses to lock the medication carts when walking away from them. On [DATE] at 2:44 p.m., the medication storage room was inspected with Licensed Practical Nurse D (LPN D). Two blood glucose meter control solution bottles were observed on the countertop in a clear plastic bag. The date written on both bottles was [DATE]. LPN D said the dates were written when the bottles were opened. Both control solution bottles contained instructions that read, in part: .discard 3 months after first opening . LPN D was asked if other bottles of control solutions were available or in use. LPN D replied, I don't know. One of the cupboards in the medication room revealed two unopened boxes of glucose meter control solutions. During an interview with the DON on [DATE] at 8:05 a.m., the DON said the glucose control solutions should have been discarded within 90 days of opening. The policy Medications dated as revised [DATE] read, in part: .The medication cart will be locked when unattended . The policy Glucometer: Control Testing and Cleaning dated as last revised on [DATE] read, in part: .Policy-to ensure that blood glucose results are accurate .Glucose Control Solutions .Use before expiration date and discard any unused portion 90 days after opening. Date opened to be written on solution box . The manufacturer instruction manual for the blood glucose meter used by the facility read, in part: .Discard the used control solution and repeat the test using a new bottle of control solution .when the control solutions is past its discard date (the date the bottle was opened plus three (3) months) .

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility failed to ensure a correct therapeutic diet was prescribed for 2 Residents (#25 and #41) of 5 Residents reviewed for nutritional issues. This deficient practice resulted in the potential for unmet nutritional needs and the potential for health complications. Findings include: Resident #25 (R25) R25 was admitted to the facility 8/19/2020 with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety, dysphagia (difficulty swallowing) and diabetes mellitus. The Minimum Data Set (MDS) assessment dated [DATE] revealed R25 was totally dependent for eating meaning the helper does ALL of the effort. R25 was also coded as dependent for dressing, bathing, toileting and personal hygiene. The Brief Interview for Mental Status (BIMS) assessment was not attempted and was coded No (resident is rarely/never understood). The physician orders included a Diet order: CCD NAS, Pureed (carbohydrate controlled diet, no added salt, pureed). On 11/19/24 at 8:25 AM, the breakfast meal for R25 was observed served in a three-compartment divided dish with only one compartment containing a beige scoop of a pureed item. The tray card indicated R25 should receive: Pureed Breakfast Skillet - 3 oz (ounces) and Pureed Toast - #8 Scp (#8 scoop is 3.75 oz). R25 was also to receive apple sauce - 1/2 cup, but was served a pre-portioned ready to serve 1/4 cup. The tray card included instructions of No Pepper Packets. This tray included pepper. During an interview on 11/19/24 at approximately 8:30 AM, dietary cook C, who prepared the breakfast, stated I just mixed the bread with the breakfast skillet and gave 2 ladles (2 oz each). During an interview on 11/19/24 at 3:16 PM, Certified Dietary Manager (CDM) A reviewed the therapeutic menus and stated the cook should have pureed breakfast skillet and pureed toast separately and the residents should be served the serving sizes and preferences listed on the tray card. R25 received 4 oz of a mixed product and should have received approximately 4 oz of toast and 3 oz of the breakfast skillet recipe. On 11/20/24 at 8:27 AM, R25 was observed with breakfast served in a three-compartment divided dish with only one compartment containing a beige scoop of Krupsua (a Finish baked breakfast custard). All other residents received a square formed serving of the Krupsua. R25 was also to receive apple sauce - 1/2 cup, but again was served a pre-portioned ready to serve 1/4 cup. The tray card included instructions of No Pepper Packets. Two pepper packets were served on the tray. On 11/20/24 at approximately 11:55 AM, R25 was observed with two pepper packets on her tray and the tray card read No Pepper Packets. The staff member (Staff L) assisting R25 with her meal stated, They continue to put pepper on the tray. I guess some people don't read. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 2:45 PM, CDM A was unsure why R25 should not get pepper packets and stated it may be because she would eat the paper packets of pepper. CDM A stated he would expect the cooks to follow the recipes and the tray cards and the puree Krupsua should be a square formed serving for all residents including those receiving a pureed diet. Resident #41 (R41) R41 was admitted on [DATE] with diagnoses including chronic (CHF) congestive heart failure (primary diagnosis),high blood pressure, fluid overload and diabetes mellitus. The physician orders included Diet Order Instructions: 2,000 ml (milliliters) Fluid Restriction 480 ml with meals 240 ml BID (twice daily) with medication pass 40 ml excess fluid per day. On 11/19/24 at 8:12 AM, the breakfast tray for R41 was observed and contained 120 ml of orange juice, 180 ml of coffee, and 120 ml of cranberry juice. R41 requested he substitute his 120 ml of cranberry juice for milk so he could use it with his dry cereal. He was given 240 ml of milk resulting in a total of 540 ml for the meal. On 11/19/24 at 3:47 PM, R41 was observed to have a water jug with ice water filled past the top 280 ml mark on the vessel. R41 stated the staff had just passed the ice water and he usually got ice water once a day or so. On 11/19/24 at 4:04 PM, R41 was frustrated and stated, I keep peeing all the time. Something is wrong. On 11/20/24 at 7:45 AM, R41 was in the main dining room waiting for his breakfast to be served. He had a 180 ml cup of coffee and had an empty 180 ml of coffee in front of him. R41 stated, I haven't got to that one yet. Eleven minutes later at 7:56 AM, R41 had his breakfast tray served with two cups of 120 ml orange juice and 180 ml of coffee. R41 stated he only wanted one glass of orange juice. The Licensed Practical Nurse (LPN) K who was assisting in the main dining room said, I don't know why you got two, if you don't want them you don't have to drink them. LPN K seemed unaware of the fluid restriction. Later during the breakfast meal R41 was observed drinking his third cup of coffee. (The total observed fluid consumption for the meal was 660 ml.) On 11/20/24 at 10:01 AM, R41 was observed in activities watching a musical group. Many of the residents had beverages while they listened to the entertainment. R41 had a 180 ml mug in front of him even though the ordered fluid restriction plan only included fluids with meals and medication passes. During an interview on 11/21/24 at 9:16 AM, a fluid report was reviewed by the Director of Nursing (DON) and the Clinical Consultant Registered Nurse (RN) M. The report did not reflect all the fluids consumed by R41. For example: breakfast of 11/20/24 with 3 cups of coffee (180 ml each) and a glass of orange juice (120 ml) was recorded as 120 ml rather than the actual 660 ml. The water pass sheet indicated R41 should not receive bed side water due to the physician ordered fluid restriction but approximately 300 ml of ice water was served on 11/19/24. The care plan in the medical record for R41 included concerns for weight fluctuations with CHF and edema with a diuretic and indicated a plan, I will attempt to maintain my recommended 2,000 ml Fluid Restriction 480 ml with meals, 240 ml BID with medication pass 40 ml excess fluid per day with nursing assistance. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled Intake and Output and dated as most recently revised 12/22/2015, read in part: Policy: To ensure adequate hydration and provide a monitoring system for potential over-hydration or dehydration . Procedure: A. Intake and Output (I&O) will be initiated for the following: . 8. For specific diagnoses that include, but are not limited to: . h. Fluid Restriction . B. I&O should be measured and recorded ACCURATELY every shift .

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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. 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 76 residents of the facility. Findings include: On 11/19/24 at approximately 7:20 AM, during morning meal service, a stainless steel pan of the pureed meal was observed on the steam table. [NAME] B was asked to identify the pureed food, to which she stated was, eggs, sausage and hashbrown potatoes. The temperature was measured with a metal stem probe thermometer and found to be 115 F. An interview with [NAME] B was conducted at this time and learned the food was put through a blender process and placed in the steam table. When the measured temperature was shared with [NAME] B, she stated that's not good. [NAME] B then placed the pan into the steamer to reheat. At 7:50 AM an interview was conducted with [NAME] B who was asked what temperature she had re-heated the food to. [NAME] B stated it had been reheated to 135 F. When asked if she knew what the temperature of reheated food was to be to, [NAME] B stated 165? [NAME] B also stated the temperature of the food had not been measured following the puree process. The FDA Food Code 2017 states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above; Also: 3-403.11 Reheating for Hot Holding. (A) Except as specified under (B) and (C) and in (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C (165 F) for 15 seconds. On 11/19/24 at approximately 11:15 AM, Food Service Worker (FSW) C was observed conducting dish washing activities in the three compartment sink. FSW C was observed to wash and rinse food preparation equipment (blender bowl, mixing bowls, utensils), then place into the sanitizing solution for approximately two seconds, after which they were removed and placed on a rack to drain and dry. An interview with FSW C was conducted at this time and asked what his understanding was of using the sanitizing solution. FSW C stated he was taught to dunk the equipment in the solution and had never been told that a minimum of 60 seconds of immersion was required for proper sanitizing of the equipment. A review of the container of sanitizer, identified as a quaternary ammonium (Quat) and required a contact, or immersion time, of a minimum of 60 seconds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235367	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norlite Nursing Center	701 Homestead St Marquette, MI 49855

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the FDA Food Code states: 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: (C) A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24 C (75 F), P (2) Have a concentration as specified under S 7-204.11 and as indicated by the manufacturer's use directions included in the e labeling, On 11/20/24 at 11:11 AM [NAME] B was observed preparing the noon meal, which included the use of the steamer equipment, located under the exhaust hood. [NAME] B was observed to open the door of the steamer, which at that time, released an enormous volume of steam. It was further observed the exhaust hood was unable to capture the volume of steam created and released by the equipment, and was estimated to allow over 60% of the released steam to roll up the front of the canopy of the hood and then roll across the kitchen ceiling. The steam was then observed to condense on the ceiling creating droplets of water which then dripped down to the floor potentially contaminating food being carried in the area. This condition was observed an additional three times during the food preparation. An interview was conducted with [NAME] B on 11/20/24 at approximately 11:25 AM concerning the release of the steam into the working area. [NAME] B stated this had been ongoing for as long as she could remember and felt it was a problem. On 11/20/24 at approximately 12:45 PM, an interview with Kitchen Manager (KM) A was conducted, who confirmed the ongoing problem with the inability of the exhaust hood to capture the volume of steam and smoke produced by the cooking equipment. On 11/20/24 at approximately 1:10 PM additional observations of the exhaust hood were made. Using a simple test of holding a paper towel to the filters of the hood, there was a demonstrated weak pull, or negative pressure being created by the motors of the unit. Further, the hood, not being a compensating type hood, in which exterior air is pushed into the kitchen to aid in funneling smoke and steam into the canopy and out the exhaust, created a low volume of make up air in the kitchen. It appeared the exhaust volume was not properly engineered to capture the volume of smoke and steam produced, nor was it capable of providing an equal volume of incoming air to balance the exhaust volume. Additional interview with KM A at this time confirmed the ongoing problem with the exhaust system in the kitchen. The FDA Food Code 2017 states: 4-301.14 Ventilation Hood Systems, Adequacy. Ventilation hood systems and devices shall be sufficient in number and capacity to prevent grease or condensation from collecting on walls and ceilings. And (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6-304.11 Mechanical. If necessary to keep rooms free of excessive heat, steam, condensation, vapors, obnoxious odors, smoke, and fumes, mechanical ventilation of sufficient capacity shall be provided.