STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235373	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Lodge Trinity Health	18525 Woodland Ridge Drive Spring Lake, MI 49456

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review the facility failed to 1.) Administer controlled medications following a physician's order and professional standards of practice and 2.) Ensure that medications were administered following the physician-ordered parameters for 4 residents (Resident #1, Resident #14, Resident #32, and Resident #57), reviewed for medication administration, resulting in medication errors and the withholding of medications without a physician's order. Findings include: Resident #1 (R1): Review of an Admission Record revealed R1 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: spastic quadriplegic cerebral palsy. Review of R1's Order Summary revealed, Norco Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth three times a day for pain -Start Date-11/28/2023. To be administered at 5:00 AM, 12:00 PM, and 8:00 PM. Review of R1's Controlled Substance Record revealed on 6/20/24 R1 received a dose of Norco at 6:10 am and 11:51 AM. R1 was not administered the 8:00 PM dose. Review of R1's Medication Administration Record revealed that the 8:00 PM dose of Norco was documented as administered. Review of R1's Controlled Substance Record revealed on 6/21/24 R1 received a dose of Norco at 5:15 AM, 8:00 PM, 11:50 AM, and 7:30 PM. Indicating an additional dose of Norco administered. Review of R1's Medication Administration Record revealed only that the 5:00 AM, 12:00 PM, and 8:00 PM doses of Norco were administered. Resident #14 (R14): Review of an Admission Record revealed R14 was an [AGE] year-old male, admitted to the facility on [DATE]. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 10 unit subcutaneously before meals for DM give with breakfast and lunch. Hold if BS (blood sugar) <120 -Start Date-05/03/2024 to be administered at 8:30 AM, 11:30 AM, and 5:30 PM. Review of R14's Medication Administration Record revealed: *On 06/08/2024 at 5:45 AM R14's blood sugar was 118 and the Lispro was administered. *On 06/09/2024 at 4:42 PM R14's blood sugar was 104 and the Lispro was administered. *On 06/13/2024 at 5:43 AM R14's blood sugar was 110 and the Lispro was administered. *On 06/13/2024 4:00 PM R14's blood sugar was 116 and the Lispro was administered. *On 06/17/2024 at 7:00 AM R14's blood sugar was 111 and the Lispro was administered. Resident #32 (R32): Review of an Admission Record revealed R32 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R32's Order Summary revealed: Norco Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth in the morning for Pain -Start Date- 04/26/2024. Norco Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain -Start Date- 04/25/2024. Review of R32's Controlled Substance Record revealed on 6/14/24 R32 received a dose of Norco at 5:45 AM, 8:26 AM, 4:45 PM, and 10:45 PM. Review of R32's Medication Administration Record revealed the as needed dose of Norco administered at 10:45 PM was not documented. Review of R32's Controlled Substance Record revealed on 6/16/24 R32 received a dose of Norco at 1:00 AM, 8:30 AM, 3:10 PM, and 12:00 AM (6/17/24). Review of R32's Medication Administration Record revealed the as needed dose of Norco administered at 12:00 AM (6/17/24) was not documented. Review of R32's Controlled Substance Record revealed on 6/22/24 R32 received a dose of Norco at 5:45 AM, 7:32 AM, 1:30 PM, and 7:30 PM. Review of R32's Medication Administration Record revealed the as needed doses of Norco administered at 5:45 AM, 1:30 PM, and 7:30 PM were not documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R32's Order Summary revealed, amLODIPine Besylate Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet by mouth in the morning for HTN (hypertension) HOLD FOR SBP <120 (systolic blood pressure less than 120)-Start Date- 05/15/2024 -D/C Date-06/20/2024 to be administered upon rising. Review of R32's Medication Administration Record revealed: *On 6/4/24 R32's blood pressure was 112/60 and the amlodipine was administered. *On 6/5/24 R32's blood pressure was 116/68 and the amlodipine was administered. *On 6/18/24 R32's blood pressure was 118/71 and the amlodipine was administered. Review of R32's Order Summary revealed, Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN with meals- HOLD for SBP <120 -Start Date- 05/14/2024 to be administered at 8:00 AM and 4:30 PM. *On 6/3/24 R32's blood pressure was 110/60 and the morning dose of carvedilol was administered. *On 6/3/24 R32's blood pressure was 116/62 and the afternoon dose of carvedilol was administered. *On 6/4/24 R32's blood pressure was 116/63 and the morning dose of carvedilol was administered. *On 6/4/24 R32's blood pressure was 114/66 and the afternoon dose of carvedilol was administered. Resident #57 (R57): Review of an Admission Record revealed R57 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R57's Order Summary revealed, Lisinopril Tablet 5 MG Give 5 mg by mouth in the morning for hypertension Hold for SBP <100, pulse <60. -Start Date- 11/16/2023 to be administered upon rising. Review of R57's Medication Administration Record revealed that the Lisinopril was administered daily from 6/1/24 to 6/26/24. Review of R57's Blood Pressure Summary and Pulse Summary revealed that for the month of June 2024, R57's blood pressure and pulse were assessed one time on 6/10/24. There was no documentation that licensed nurses ensured R57's vital signs were within the ordered parameters prior to administering the medication. During an interview on 06/26/2024 at 1:16 PM, Previous Director of Nursing (PDON) N reported that physician ordered parameters should be reviewed prior to each medication administration and followed by the licensed nurses. PDON N reported that following physician ordered parameters was cited on the 2023 annual recertification survey and medication administration was monitored closely to ensure compliance. PDON N reported the Team Leads (Unit Managers) were responsible for reviewing orders and progress notes and that the expectation is for the licensed nurses to administer medication as it is ordered. (PDON N was the DON from 3/20/23-5/9/24). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/24 at 02:43 PM, Director of Nursing (DON) confirmed the narcotic medication errors for R1 and R14. DON reported that the licensed nurses were expected to follow the parameters ordered by the provider and education would begin immediately for all nurses. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, (Nurses) are responsible for documenting any preassessment data required of certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of Warfarin, before giving the medication. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Never document that you have given a medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 610). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, The National Coordinating Council for Medication Error Reporting and Prevention (2018) defines a medication error as any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/ or failing to administer a medication. Preventing medication errors is essential. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 605). Elsevier Health Sciences. Kindle Edition.

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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** 37577 Based on observation, interview, and record review, the facility failed to provide timely care for two residents (Resident #1 and Resident #53) of three residents reviewed, who are dependent on staff to meet their needs. Findings include: Resident #1(R1): Review of an Admission Record revealed R1 was a [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of quadriplegic cerebral palsy and difficulty speaking. Review of a Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 indicating R1 was cognitively intact despite not always being able to communicate her needs. R1 was completely dependent on staff for Activities of Daily Living (ADL) such as bathing, going to the bathroom, getting dressed, and eating. During an observation on 06/25/24 at 7:24 AM, the call light monitoring system showed that the call light in R1's room had been activated at 6:57 AM and remained on. During an interview on 06/25/24 at 7:28 AM, R1's call light remained on and she laid in bed and answered the following questions: yes she is waiting for help, yes she is wet, no she did not get changed during the night last night, yes it usually takes a long time for someone to answer her call light, no staff did not reposition her during the night last night, and yes this surveyor could wait with her until staff came to answer the call light. Staff entered R1's room to offer assistance at 8:00 AM, 1 hour and 3 minutes after R1 activated the call light system. Review of Care Plans for R1 revealed the following staff interventions that R1 required to meet her highest practicable physical and psychological well being: (1) Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance, (2) anticipate and meet my needs, (3) keep skin clean and dry, (4) I sometimes cannot fully form words, but I grunt when I want to make something known. I also can nod my head to yes and no questions, or say yes or no, (5) promote my comfort, and (6) I require 1 person for toileting needs including brief changes and using a bed pan. Review of a Braden Score for Predicting Pressure Sore Risk for R1 dated 06/24/24, revealed R1 was at High Risk for skin breakdown. Resident #53 (R53): Review of an Admission Record revealed R53 was an [AGE] year old female, originally admitted to the facility on [DATE], with pertinent diagnoses of recent surgery to the right knee for an infected total knee replacement. During an observation on 06/26/24 at 7:10 AM, the call light monitoring system showed that the call light in R53's room had been activated at 6:41 AM and remained on. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24 at 7:15 AM, R53's call light remained on and she laid in bed and stated the following: I am soaked, I need to be changed. When asked if she had been changed during the night she stated no. While waiting with this resident she stated I don't think there is anyone to help me. Staff entered the room to assist R53 at 7:44 AM. R53 stated the bed is soaked. While assisting R53, the aide placed a blanket over the large urine soaked spot on R53's bed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview and record review, the facility failed to 1.) Provide care following professional standards of practice and facility policy to prevent the development of an avoidable pressure injury and 2.) Promptly notify the family/emergency contact and provider of a newly-identified pressure injury for one resident (Resident #10) out of 6 residents reviewed for alterations in skin integrity/pressure injuries, resulting in the development of a pressure injury and a delay in treatment. Findings include: Resident #10 (R10): Review of an Admission Record revealed R10 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Review of a Minimum Data Set (MDS) assessment for R10, with a reference date of 3/14/24 revealed in Section C-Cognitive Patterns that R10 was severely cognitively impaired. Review of Section M-Skin Conditions revealed R10 did not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. R10 was identified as at risk of developing pressure ulcers/injuries. Review of R10's Functional Abilities and Goals dated 6/15/24 revealed that R10 was dependent on staff for bathing, dressing, toileting, and mobility. Review of R10's Braden Scale for Predicting Pressure Sore Risk dated 6/8/24 revealed a score of 12-high risk for the development of a pressure injury. Review of R10's Skin Care Plan last revised 4/22/20 revealed, The resident is at risk for alteration of skin integrity .Encourage &/or assist with repositioning as resident will allow Date Initiated: 04/15/2021. Review of R10's Care Plans did not include a repositioning schedule, pressure offloading devices, or any pressure injuries/skin breakdown remedies. During an observation on 06/24/24 at 09:34 AM, R10 was up in a Broda chair in front of the television in a communal area, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/24/24 at 11:50 AM, R10 was up in a Broda chair at the dining room table, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/24/24 at 01:47 PM, R10 was up in a Broda chair in her room, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/24/24 at 03:51 PM, R10 was up in a Broda chair in her room, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/25/24 at 07:24 AM, R10 was up in a Broda chair in the doorway of her room, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/25/24 at 08:02 AM, R10 was up in a Broda chair in the doorway of her room, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/25/24 at 08:56 AM, R10 was up in a Broda chair at the dining room table, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/25/24 at 09:31 AM, R10 was up in a Broda chair in front of the television in a communal area, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/25/24 at 11:00 AM, R10 was up in a Broda chair in front of the television in a communal area, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation on 06/25/24 at 12:19 PM, R10 was up in a Broda chair at the dining room table and staff were assisting her with eating, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. During an observation and interview on 06/25/24 at 03:14 PM, R10 was up in a Broda chair in her room, her head was tilted slightly towards the right, there were no offloading devices in place, and her feet/heels were resting directly on the footrest. Certified Nursing Assistant (CNA) R reported that R10 prefers to stay up in her Broda/geri chair most of the time. CNA R reported R10 was not care planned for scheduled repositioning (every 2 hours) or for limited time up in her chair. Review of R10's Skin Assessment, dated 6/10/24, revealed that R10's skin was intact. Review of R10's Skin Assessment, dated 6/17/24, revealed, Small open area on left buttocks 0.5 cm x 0.3 cm. Barrier cream applied and Optifoam dressing in place. Review of R10's Electronic Health Record revealed no documentation that R10's physician or family member/responsible party was notified of the newly identified pressure injury. Review of R10's Treatment Administration Record and Order Summary revealed no documentation that a treatment order was initiated on 6/17/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R10's Incident Report dated 6/20/24 revealed, Incident Description-Open area 1 cm x 1 cm noted on coccyx .(Intervention) Reposition resident every two hours as allowed .Family Member (notified) 6/21/24 at 7:01 (AM) . Indicating the worsening/increase in size of the pressure injury from the previous assessment. Review of R10's Nurse's Note dated 6/21/2024 revealed, Open area 1 cm x 1 cm noted on coccyx. Action: Cleansed with NS and Opti foam applied. Reposition resident every two hours as allowed. R10's Care Plan was not updated to reflect repositioning every 2 hours. Review of R10's Order Summary dated 6/21/24 revealed, Cleanse coccyx with NS (normal saline). Apply Opti foam dressing every night shift every Mon, Wed, Fri for Open area. (4 days after the identification of a pressure injury). Review of R10's Care Plan initiated on 6/25/24 revealed, Focus: Documented Pressure Ulcer Documented Pressure Ulcer (sic) to coccyx .Goal: Management of Pressure Ulcer .Interventions/Tasks: Monitor ulcer for signs of progression or declination-Notify provider if no signs of improvement on current wound regimen-Provide wound care per treatment order. During an interview on 06/25/24 at 03:53 PM, Family Member (FM) S reported he was notified that R10 had a pressure injury a couple days ago. FM S stated R10 can't move much anymore and required staff to assist with bed mobility and repositioning. During an interview via email at 06/26/24 at 1:47 PM, Nursing Home Administrator (NHA) stated that the Wound Care Nurse will look at her (R10) tomorrow (6/27/24) as Incident (pressure injury) found 6/20/(24). During an interview on 06/26/2024 at 12:53 PM, Wound Care Nurse (WCN) N (previous Director of Nursing) reported that she assessed residents with wounds weekly on Thursdays. WCN N had not been notified of a pressure injury on R10's coccyx on 6/17/24 or when she was completing wound rounds at the facility on 6/20/24. During an observation and interview on 06/27/24 at 11:55 AM, WCN N measured R10's coccyx wound with a 0.3 cm x 0.2 cm scab like center and reported it appeared as a healing open area. WCN N reported that surrounding the scab like center was superficial epithelial tissue loss and measured 2.5 cm x 2 cm and likely resulted from a mixture of MASD and positioning pressure but has now dried. No treatment changes were made at that time. Review of the facility policy Wound Care/Skin Integrity dated 2/1/21 revealed, Observation of all patient's skin is required every shift and must be reported to the oncoming shift RN and CENA with the Nursing Hand Off.MOBILITY DEFICIT *Patients that are Braden 14 or less are to be repositioned every 2 hours, unless contraindicated by primary diagnosis, complications, or co-morbidities .elevate lower extremities to keep heels off of the mattress . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Repositioning (turning) patients is a consistent element of evidence-based pressure injury prevention (EPUAP, NPIAP, PPPIA, 2019a). The twofold aim of repositioning should be to reduce or relieve pressure at the interface between bony prominence and support surface (bed or chair) and to limit the amount of time the tissue is exposed to pressure (Maklebust and [NAME], 2016). Elevating the head of the bed to 30 degrees or less decreases the chance of pressure injury development from shearing forces (WOCN, 2016). Change the immobilized patient's position according to tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort (EPUAP, NPIAP, PPPIA, 2019a). A standard turning interval of 1.5 to 2 hours does not always prevent pressure injury development; repositioning intervals are based on patient assessment. Some patients may need more frequent position changes, while other patients can tolerate every-2-hour position changes without tissue injury. When repositioning, use positioning devices to protect bony prominences (WOCN, 2016). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1255). Elsevier Health Sciences. Kindle Edition.

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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** 39056 Based on observation, interview, and record review, the facility failed to ensure that a resident with limited mobility received appropriate/recommended equipment for one resident (Resident #10) out of 6 residents reviewed for range of motion, positioning, and mobility. Findings include: Resident #10 (R10): Review of an Admission Record revealed R10 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Review of a Minimum Data Set (MDS) assessment for R10, with a reference date of 3/14/24 revealed in Section C-Cognitive Patterns that R10 was severely cognitively impaired. Review of R10's Functional Abilities and Goals dated 6/15/24 revealed that R10 was dependent on staff for bathing, dressing, toileting, and mobility. Review of R10's Screen Request for Potential Risk or Intervention and Therapy Orders dated 10/6/22 revealed the therapy department provided dumped (seat slope/recline), high back w/c (wheelchair)-10/7/22. The wall in R10's room held a picture of R10's high back wheelchair with the therapy recommended equipment in place. Written on the picture were instructions for the equipment R10 required. Legs: foot buddy on top of leg rests and secured with straps. Cushions: back/lateral supports on back rest. cushion on seat. bolster on (right) armrest. Review of R10's Care Plan did not reflect the type of chair R10 was to utilize (high back wheelchair or Broda chair) and did not indicate the type of equipment/cushions recommended by therapy. During an observation on 06/24/24 at 09:34 AM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/24/24 at 11:50 AM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/24/24 at 01:47 PM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/24/24 at 03:51 PM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/25/24 at 07:24 AM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/25/24 at 08:02 AM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/25/24 at 08:56 AM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/25/24 at 09:31 AM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/25/24 at 11:00 AM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/25/24 at 12:19 PM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/25/24 at 03:14 PM, R10 was sitting up in a Broda chair and did not have a foot buddy, cushions, or a bolster in place. During an observation on 06/26/24 at 12:47 PM, R10's high back wheelchair with foot buddy on top of leg rests, back/lateral support cushion on back rest, cushion on seat, and bolster on right armrest was in her bathroom in the shower area. During an observation on 06/27/24 at 08:57 AM, R10 was up in a Broda/geri chair at the dining room table. R10's high back wheelchair with foot buddy on top of leg rests, back/lateral support cushion on back rest, cushion on seat, and bolster on right armrest was in her bathroom in the shower area. During an interview on 06/27/24 at 08:59 AM, Certified Nursing Assistant (CNA) P reported that R10 had not used the high back wheelchair in her bathroom for at least a couple months and was in a Broda chair. CNA P reported that the chair she was utilizing suits her better. CNA P reported that she believed that R10 recently had a therapy evaluation/assessment and was changed to the Broda/geri chair. During an interview on 06/27/24 at 09:16 AM, Therapy Manager (TM) O reported that R10 had not had a therapy evaluation/assessment since 9/21/23 when R10 had a decline in her functional abilities. TM O reported there had been no chair assessments since her therapy evaluation/assessment. During an observation and interview on 06/27/24 at 11:50 AM, R10's high back wheelchair with foot buddy on top of leg rests, back/lateral support cushion on back rest, cushion on seat, and bolster on right armrest was in her bathroom in the shower area. Previous Director of Nursing (PDON) N reported she was familiar with R10 but did not know why that chair was not being used and was unaware of an equipment/wheelchair order change and/or a recent therapy evaluation. (PDON N was the DON from 3/20/23-5/9/24 and continued to work at the facility as the wound nurse.) During an interview on 06/27/24 at 12:07 PM, Licensed Practical Nurse (LPN) Q reported that she was routinely R10's nurse. LPN Q reported that she had not worked the last few days and was unsure why R10 was not in her modified high back wheelchair. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 12:19 PM, TM O provided a therapy evaluation/assessment and confirmed that R10 was last seen by the therapy department in September of 2023 and was using a high back, recline, wheelchair. TM O reported that R10's transfer ability had declined, and it was recommended that she be transferred using a Hoyer lift instead of an EZ-stand but a change from her high back wheelchair to a Broda chair was not recommended. TM O reported that R10 should be using the high back wheelchair with the cushions, bolsters, and foot buddy based on the most recent therapy evaluation but was currently using a Broda chair. Review of R10's OT (Occupational Therapy) Therapist Progress & Discharge Summary revealed, Start of Care 9/21/23-End of Care 10/4/23. Occupational Therapist recommended the transfer change from an EZ-stand to a Hoyer lift. The records did not reflect a change from the high-back wheelchair to the Broda chair. During an interview on 06/27/24 at 01:27 PM, DON reported that she would be obtaining an order for a therapy evaluation for R10's Broda chair vs. high back wheelchair. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (In conjunction with an interprofessional health care team, develop an early intervention protocol using prescribed positioning, ROM exercises, and/or splints to reduce the risk of joint deformity and contracture formation ([NAME] and [NAME], 2018). o Health care agencies need to provide equipment (e.g., splints) and appropriate education for staff to reduce the risk of contractures .Use positioning and ROM and stretching exercises according to the individualized need of the patient and as ordered. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 879). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Sound clinical judgment involves using the resources needed to maintain a patient's function and independence. For example, it is important to collaborate with health care providers and physical and occupational therapists .Occupational therapists assist patients with adaptive devices and techniques to perform ADL's while improving mobility .In addition, always individualize a plan of care directed at meeting the actual or potential needs of the patient. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 841). Elsevier Health Sciences. Kindle Edition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to follow its established protocol to provide residents with clean oxygen delivery equipment and to monitor oxygen levels for one resident (Resident #11) of 3 residents reviewed. Findings include: Resident #11 (R11): Review of an Admission Record reflected R11 was a [AGE] year-old female, last admitted to the facility on [DATE]. During an observation on 06/24/24 at 11:10 AM, R11 sat up in bed awake and alert. R11 reported using oxygen at night while sleeping. The oxygen tubing and bottle of water to humidify the oxygen were dated 06/05/24. During an observation on 06/25/24 at 7:09 AM R11 laid resting in bed with eyes closed and received oxygen via a nasal cannula. The oxygen tubing and bottle of water to humidify the oxygen were dated 06/05/24 and the bottle of water was empty. During an interview on 06/25/24 at 9:30 AM the Director of Nursing (DON) stated the all oxygen tubing and equipment are changed out weekly by third shift staff. During an observation on 06/26/24 at 9:36 AM R11 sat up on the side of the bed eating breakfast. R11 stated that she had used oxygen last night. The oxygen tubing and bottle of water to humidify the oxygen were dated 06/05/24 and the bottle of water was empty. During an observation on 06/27/24 at 11:45 AM R11 sat in a wheelchair watching TV. R11 reported that last night staff replaced the bottle of water used to humidify the oxygen. The bottle of water was dated 06/26/24. However, the oxygen tubing was still dated 06/05/24. Review of an 02 Sats (oxygen saturations) Summary for R11 showed the last time staff had monitored/documented R11's blood oxygen saturation occurred on 03/07/24. Review of a Physician Order Summary for R11 revealed no order for oxygen delivery, the rate of delivery, and the method of oxygen delivery.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview, and record review, the facility failed to operationalize policies and procedures and have a functional system in place for controlled substances to ensure that they were accounted for, dispensed, and disposed of in a sensical manner, resulting in the potential for drug diversion and the misappropriation of property. Findings include: Resident #65 (R65): During an observation and interview on [DATE] at 7:52 AM, the 200 Hall Registered Nurse (RN) A (night shift nurse) and Licensed Practical Nurse (LPN) D (oncoming nurse) were exchanging report and destroying a Schedule II narcotic (Norco (Hydrocodone/acetaminophen)). A blister pack of Norco ,d+[DATE] mg tablets had 23 tablets left from a 30-count blister pack for Resident #65 (R65). Both nurses entered the medication storage room and RN A popped the 23 tablets into his hand and discarded them into the drug buster bottle (a medication disposal system that quickly turns most non-hazardous medications into a non-toxic slurry that can be safely put in the trash). Neither nurse signed a document indicating that the 23 Norco tablets were counted and destroyed. The nurses reported they wanted to discard the 23 Norco tablets to not confuse anyone with the new increased dosage of Norco for R65. RN A and LPN D reported there was not a form to fill out for destroying the narcotic. Review of the Individual Resident's Controlled Substance Record dated [DATE]rd for R65 revealed handwritten information: [R65] Take 1-tab TID (three times a day) + 1 PRN (as needed) @ HS (at bedtime). No medication or dosage was identified on the sheet. The first entry on the page dated [DATE] at 1:15 PM shows amount on hand is 120, amount received is 120 with a circle around it and initials with a date of , d+[DATE]. One tablet was given and the amount remaining was 119. On [DATE] at 9:45 PM the count was at 83. On [DATE] at 7:00 AM, after the disposal of the 23 Norco's at ,d+[DATE] mg, one tablet was given at 7:00 AM and the count remaining was 59. At the top of these forms is a box that states Disposition of Remaining Doses- Per Facility Policy with space to sign, date, and document the quantity of medication disposed. During an observation and an interview on [DATE] at 8:00 AM, the 200-hall medication cart revealed R65 had 59 tablets of the Norco 7XXX,d+[DATE] mg remaining in the cart. LPN D verified that the Controlled Substance Record for R65 did not have the name of the Norco medication or the dosage on it. She clarified the document was a combination of both doses of Norco (,d+[DATE] mg and the 7XXX,d+[DATE] mg). The form was originally for the Norco ,d+[DATE] mg and new orders were obtained to increase the dosage of Norco to 7XXX,d+[DATE] mg. The document is unclear about what Norco dose was started, what dose was given, and when it was changed. LPN D thinks that whoever checked in or received the new prescription of Norco 7XXX,d+[DATE] mg combined the medication with the previous dose and logged them on the same sheet. The count of 83 tablets on [DATE] is the combination of both strengths, but since they wasted the 23 Norco ,d+[DATE] mg tablets this morning, the count is now at 59 tablets of the Norco 7XXX,d+[DATE] mg tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Individual Resident's Controlled Substance Record for R65 revealed on [DATE] 120 tablets of Norco ,d+[DATE] mg was delivered and signed by two nurses. On [DATE] at 6:20 AM the first dose was documented as given. On [DATE] at 7:10 PM 1 ,d+[DATE] pills were documented as given (equivalent to 7XXX,d+[DATE] mg). A total of 6 doses of 1 ,d+[DATE] tablets were given until [DATE] when 107 tablets were left. There is no account of where these 107 tablets are. There is no destruction log for these tablets. Review of the Individual Resident's Controlled Substance Record for R65 revealed on ,d+[DATE] a delivery of 120 tablets of Norco 7XXX,d+[DATE] mg were delivered signed by two nurses as receiving 120 tablets. The number 30 was handwritten under the printed label 120 EA. On [DATE] at 6:00 PM the AMOUNT ON HAND count is 120 and 1 tablet was given with 119 tablets remaining. The 119 has a line through it and the number 29 is handwritten next to it. The amount remaining was crossed off and changed a total of 7 times changing the original amount remaining of 119 tablets - 113 tablets between [DATE] to [DATE], to 29 tablets - 23 tablets remaining during that period. That leave 90 tablets of Norco unaccounted for. Review of the May and [DATE] Medication Administration Record (MAR)for R65 revealed several orders for Norco. The original order for Norco ,d+[DATE] mg started [DATE] and discontinued on [DATE]. On [DATE] was the first order for Norco 7XXX,d+[DATE] mg. In an interview on [DATE] at 9:20 AM, the Director of Nursing (DON) reviewed the 200 Hall medication cart and verified the Individual Resident's Controlled Substance Record for R65 was not accurately documented when received, accounted for, and disposed of. There should always be 2 nurses wasting medications and documenting what medication was wasted how much. The DON verified the record did not reflect the name of the medication or the dosage. The DON reported she had some education to do. In an interview on [DATE] at 11:30 AM, the DON reported the pharmacy was sending the medication narcotic delivery records to the facility and will give them to us as soon as they receive them. The DON reported the facility does not practice splitting medication tablets and does not have the capability to do so. When referencing R65's narcotic log, the DON agreed that is must have happened but not clear of the details yet. The DON reported the facility just switched pharmacy providers within the last ,d+[DATE] weeks and have a hybrid of both pharmacy medications in the facility at this time. The facility could not find any disposal logs of the Norco's for R65 by the time of the exit. Review of a Pharmacy delivery record revealed on [DATE] 120 tablets of Norco ,d+[DATE] mg were delivered and on [DATE] 120 tablets of Norco 7XXX,d+[DATE] mg was delivered. Resident #6 (R6): During an observation, interview, and record review on [DATE] at 8:00 AM, the Individual Resident's Controlled Substance Record for R6 revealed handwritten information: Amount Received: 30 ml (milliliters), take 0.5 mL by mouth 3 times daily. The document has 2 lines of white out on it and documented 30 mL on hand. LPN D reported she did not know why the report sheet was handwritten without a medication name on it or why it had white out on it. LPN D confirmed it was for the liquid Lorazepam ordered for R6. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Individual Resident's Controlled Substance Record for R6 revealed Lorazepam with 22 mls left in a 30 ml bottle. This was verified in the medication refrigerator along with another 30 ml unopened bottle of Lorazepam. In an interview on [DATE] at 11:30 AM, the DON reported there should never be any white out on a Controlled Substance Record and will be looking into it. Review of a policy titled 6.0 General Dose Preparation and Medication Administration last revised [DATE] revealed: 2.9 Facility staff should not split tablets. 2.9.1 The pharmacy should be contacted to provide the correct dose. 5.5 Document the administration of controlled substances in accordance with applicable law. 6. 2 Dispose of unused medication portions in accordance with facility policy. Review of a policy titled 8.2 Disposal/Destruction of Expired or Discontinued Medication last revised [DATE] revealed: Procedure: 1. Facility staff should destroy and dispose of medications in accordance with Facility policy and Applicable Law, and applicable environmental regulations. 2. Once an order to discontinue a medication is received, Facility staff should remove this medication from the resident's medication supply. 3. Facility should transmit or fax a copy of the discontinue order to Pharmacy to remove it from the resident's current medication list and from the Physicians order sheet and medication administration record. 6. Facility should enter the following information on a drug destruction form when medications are destroyed: 6.1 Resident's name, 6.2 name and strength of medication, 6.3 Prescription number, 6.4 Amount of medication (dosage units) destroyed, 6.5 Date of destruction 6.6 Signature of staff destroying medications, 6.7 Signature of witnesses; and 6.8 Method of disposition, including donation as permitted by Applicable Law. 9. Controlled substances may not be returned to Pharmacy, unless refused at the time of delivery. 10 Facility should record destruction of controlled substances on: 10.1 Medication Disposition/Destruction Form; 10.2 Controlled Substance Count Form; or 10.3 Medication Destruction Logbook. 11. Facility should destroy discontinued or outdated medications by one of three (3) methods: . 11.3 Facility-approved commercially available drug disposal kits. 12. Facility should destroy Schedule II-IV controlled substances as detailed above, with the following exceptions: 12.1 Facility should destroy controlled substances in the presence of a registered nurse and a licensed professional or in accordance with Facility policy or Applicable Law. 12.2 Destruction of controlled medications should be documented on the controlled medication count sheet and signed by the registered nurse and witnessing licensed professional who should record: 12.2.1 Quantity destroyed; 12.2.2 Date of destruction; and 12.2.3 Signature of registered nurse and licensed professional.

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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. 37573 Based on observation, interview, and record review, the facility failed to discard expired medications for 1 of 3 medication carts reviewed, from a total 6 medication carts, resulting in the residents receiving medications that are expired and/or have reduced efficacy. Findings include: During an observation and interview on 6/26/24 at 8:00 AM, the 200 hall Medication cart had a bottle of eye drops with an opened date of 5/12/24, a bottle of nasal spray with a date opened of 5/2/24, a Lantus multi dose vial with an opened date of 5/10/24 and another Lantus multi dose vial with an open date of 5/8/24. Licensed Practical Nurse (LPN) D reported she was not sure of the expiration dates of the medications once they were opened but believed it was around 28 days. Review of an Insulin Storage Parameters document provided by the facility revealed Lantus is to be discarded 28 days after opening. Ophthalmic Solutions Storage Parameters: Eye medication bottles/tubes with accelerated expiration dates must be dated/initialed upon opening. Follow manufacturers instructions, or facility policy.

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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 maintain sanitary conditions in the kitchen, resulting in the potential to spread food borne illnesses to all residents that consume food from the kitchen. Findings include: During an initial tour of the walk-in cooler, at 9:44 AM on 6/24/24, it was observed that half empty box of nutritional shakes was found on the bottom storage rack. When asked if there was a date on the box of shakes, Certified Dietary Manager (CDM) J was unable to find one and stated that typically the box is dated for 14 days. A review of the items stated it was good for 14 days after thaw. When asked if the shakes are placed directly into the cooler upon receiving, CDM J stated they are first put in the freezer. During a tour of the Blue Pantry, starting at 10:23 AM on 6/24/24, it was observed that a container holding a dozen nutritional drinks were found in the refrigeration unit with no date to indicate discard. A review of the manufacturer's directions state the item is good 14 days from thaw. Further review found an open container of vanilla Med Pass 2.0 with no date to indicate discard. A review of the container stated it needed to be used within 4 days after opening. During a tour of the Yellow Pantry, at 10:34 AM on 6/24/24, two nutritional drinks were found with no date to indicate discard. According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . During a tour of the cook line, at 9:57 AM on 6/24/24, it was observed that the top of the convection oven was found with heavy amounts of dust and crumb debris with one of the oven insert racks was being stored on top of the unit. During a tour of the kitchen, at 9:59 AM on 6/24/24, it was observed that clean utensils were stored in six bins by the ice machine. When asked how often the clean utensil bins get cleaned out, CDM J stated once a week. Observation inside of the bins found an accumulation of debris and crumbs on the bottom and inside backs of the bins. CDM J stated he would get them cleaned. During a tour of the Blue Pantry, at 10:23 AM on 6/24/24, it was observed that the underside of the juice machine was found with increased amounts of brown and orange sticky residue on the underside corners of the spouts. During a tour of the [NAME] Pantry, at 10:35 AM on 6/24/24, it was observed that the underside of the juice machine was found with increased amounts of brown and orange sticky residue on the underside corners of the spouts. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During a tour of the kitchen, at 10:04 AM on 6/24/24, it was observed that three half pans were stacked and stored wet on the clean pots and pans storage rack. Further observation of the stacked pans found two quarter pans that were stacked and stored with water stuck in between. According to the 2017 FDA Food Code section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD . During the initial tour of the kitchen, at 10:08 AM on 6/24/24, observation of the dish machine found that the rinse pressure gauge only reached eight pounds per square inch (psi) after four times of cycling the machine. A review of the dish machines data plate states Flow Press. 20 +/- 5 PSI. A review of facilities dish machine log found that the rinse pressure is not something that is checked by staff and recorded. Observation of the inside of the unit found a loose screw in the top spray arm that was also impeding proper spray. (continued on next page)

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	235373	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Lodge Trinity Health	18525 Woodland Ridge Drive Spring Lake, MI 49456

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 4-501.113 Mechanical Warewashing Equipment, Sanitization Pressure. The flow pressure of the fresh hot water SANITIZING rinse in a WAREWASHING machine, as measured in the water line immediately downstream or upstream from the fresh hot water SANITIZING rinse control value, shall be within the range specified on the machine manufacturer's data plate and may not be less than 35 kilopascals (5 pounds per square inch) or more than 200 kilopascals (30 pounds per square inch). According to the 2017 FDA Food Code section 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39056 Based on interview and record review, the facility failed to 1) Implement Enhanced Barrier Precautions for residents with chronic wounds or indwelling medical devices to prevent, recognize, and control the onset and spread of infection among residents and 2) Investigate, document surveillance of, and implement preventative measures to address an outbreak of a respiratory illness among residents. Findings include: OUTBREAK INVESTIGATION Review of the Infection Prevention and Control Program revealed that in March 2024 there were 9 positive cases of Influenza A. On 06/24/2024 at 10:26 AM a request for a copy of any Line Lists and Outbreak Investigations was requested via email. There was no Line Lists or Outbreak Investigations received prior to the Infection Prevention and Control Program Review. During an interview on 06/27/2024 at 10:00 AM, the Infection Control Program was reviewed with Director of Nursing (DON) and Registered Nurse/Consultant (RNC) L. RNC L and DON were unable to locate/provide any additional outbreak investigation documentation related to the March 2024 Influenza A outbreak. DON and RNC L reported that a complete and thorough outbreak investigation should be started at the time the outbreak is identified. Review of the Infection Prevention and Control Program binders revealed a form completed on 4/1/24 titled LTC (Long Term Care) Outbreak Weekly Reporting Form The LTC Outbreak Weekly Reporting Form revealed that on 3/26/24 6 residents tested positive, on 3/27/24 2 residents tested positive, and on 3/28/24 1 resident tested positive. There was no documentation to identify: *9 residents that tested positive or contact tracing. *The date and time the Medical Director was notified of the outbreak. *The date and time the Health Department was notified of the outbreak. *The date and time the staff and residents were notified of the outbreak. *The date and time the family/emergency contacts/guardians were notified of the outbreak. *The interventions implemented to prevent the spread of Influenza-A in the facility (transmission-based precautions, increased cleaning, staff and resident education, restriction of movement between units, laboratory testing). *The daily active surveillance of all residents and staff for illness. ENHANCED BARRIER PRECAUTIONS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum (Ref: QSO-24-08-NH) with an effective Date of April 1, 2024 revealed, Memorandum Summary o CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. o EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status . Review of the Electronic Health Record, the June 2024 Monthly Infection Surveillance Log, and the Facility Matrix (802) revealed the following: *5 residents with urinary catheters *1 resident with a Peripherally Inserted Central Catheter (PICC Line) *9 residents with a pressure injury/wound *1 resident with a feeding tube Throughout the survey process from 6/24/24-6/27/24, serial observations were made throughout the facility. Observations revealed that residents with chronic wounds or indwelling medical devices were not placed in Enhanced Barrier Precautions (no signage on door or PPE carts available in/near the rooms.) During an interview on 06/27/2024 at 10:00 AM, the Infection Control Program was reviewed with Director of Nursing (DON) and Registered Nurse/Consultant (RNC) L. RNC L reported she identified on Monday (6/24/24) that Enhanced Barrier Precautions had not been implemented for residents with chronic wounds or indwelling medical devices. RNC L confirmed that Enhanced Barrier Precautions were to be implemented by April 1, 2024 per CMS guidance (QSO-24-08-NH). RNC L reported an Action Plan was initiated to implement EBP. On 6/26/24 at 1:47 PM, an Enhanced Barrier Precautions Implementation Action Plan was received via email from Nursing Home Administrator (NHA). The Action Plan identified the lack of EBP, and the steps required to implement EBP in the facility. 1. Begin education with all staff 2. Define what residents qualify for EBP-master list 3. Inventory PPE (personal protective equipment), wheeled carts/PPE holders, trash receptacles (sic) with lids 4. Evaluate availability/placement of ABHR (alcohol based hand rub) and disinf. (disinfection) wipes 5. Estimate and order needed supplies 6. Start education with residents affected (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum (Ref: QSO-24-08-NH) with an effective Date of April 1, 2024 revealed, .The new guidance related to EBP is being incorporated into F-880 Infection Prevention and Control .GUIDANCE Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: o Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or to Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. Facilities have discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC . For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: o Dressing o Bathing/showering o Transferring o Providing hygiene o Changing linens o Changing briefs or assisting with toileting o Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator o Wound care: any skin opening requiring a dressing . Facilities should ensure PPE and alcohol-based hand rub are readily accessible to staff. Discretion may be used in the placement of supplies which may include placement near or outside the resident's room. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. For example, staff entering the resident's room to answer a call light, converse with a resident, or provide medications who do not engage in a high-contact resident care activity would likely not need to employ EBP while interacting with the resident .