

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Applewood Nursing Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 18500 Van Horn Rd Woodhaven, MI 48183	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>15194</p> <p>Based on observation, interview, and record review the facility failed to ensure dignity for four residents (R15, R87, R88, and R90) out of 64 residents reviewed for resident rights on unit 200.</p> <p>Findings include:</p> <p>On 4/30/24 at 9:00 A.M. residents on the 200 unit were observed with assorted plastic ware and styrofoam containers. Resident's who ate their meals in their rooms were observed with domes that were not positioned correctly on the entree items or their food was not covered or protected while being transported from the kitchenette to their rooms.</p> <p>A random observation was conducted during the breakfast and lunch service on the 200 unit. Residents were interviewed concerning the meal experience and the use of plastic ware, Styrofoam plates, and containers.</p> <p>R15</p> <p>At approximately 9:30 A.M., R15 was observed with assorted plastic ware. The resident was queried about the food service. R15 held up the plastic spoon and responded they gave me this plastic ware; I don't know what I am supposed to use it for. Why can't we get regular silverware like the others? They deliver our food down the halls uncovered, that's a concern for me, I prefer my food covered. R15 was observed again with plastic cutlery and styrofoam plate on 5/3/24 at lunch.</p> <p>R87</p> <p>On 4/30/24 at 12:05 P.M. resident was observed with plastic ware. The resident was asked how frequently she received assorted plastic ware, R87 responded every day.</p> <p>R88 and R52</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/30/24 at 9:35 A.M., during a breakfast observation R88 was asked about the plastic silverware and styrofoam bowl on her tray. R88 indicated her meals were always served with assorted plastic and silverware. The resident commented the plastic ware was not sturdy and you could not use the knife to cut turkey without it breaking. The resident's roommate (R52) joined in the interview said, I don't know why we cannot get regular china and silverware like everyone, we do know the difference. The residents on this end of the hall get plastic even when it's not an emergency.</p> <p>R90</p> <p>On 4/30/24 at 10:52 A. M. R90 was observed with plastic silverware. The resident was asked how frequently he received plastic ware and/or styrofoam plates or containers? R90 said his food was always served with plastic ware and paper goods because he was last one served. R90 pointed to a wrapped set of stainless-steel utensils on the bedside and explain I got one complete set by accident, I put them up and the aide washes them in the room once they feed me, they are not returned to the kitchen, I won't get them back.</p> <p>On 5/1/24 at 1:30 P.M. during interview with Certified Dietary Manager (CDM) A concerning the use of plastic ware and styrofoam the manger reported sometimes staff ran out of silverware, but was not aware it was a dignity concern for the residents.</p> <p>Review of the policy Dignity revised date: 4/24 did not address dignity as it related to dietary concerns.</p>		

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<p>F 0583</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208</p> <p>Based on observation, interview, and record review the facility failed to ensure confidentiality of resident's electronic medical records for two residents (R4 and R55) out of six residents reviewed for privacy.</p> <p>Findings Include:</p> <p>During an observation on 4/30/24 at 6:30 AM on Station Two, R55's electronic medical record was visible on short hall medication cart computer screen with no nurse in attendance, with the potential for any passerby to see R55's confidential information.</p> <p>Record review R55's electronic medical record revealed admittance into the facility on [DATE] with a diagnosis of debility.</p> <p>During an observation on 5/2/24 at 8:45 AM on Station Three, R4's electronic medical record was visible on short hall medication cart computer screen with no nurse in attendance, with the potential for any passerby to see R4's confidential information. It was observed that there were approximately 10 residents in area at the time of observation.</p> <p>Record review R4's electronic medical record revealed admittance into the facility on [DATE] with a diagnosis of end stage renal failure.</p> <p>During an interview on 5/2/24 at 8:50 AM with Unit Manager (UM) L, it was reported that residents' electronic medical records should not be visible for others to see.</p> <p>During an interview on 5/2/24 at 1:30 PM with Director of Nursing, it was reported that residents' electronic medical records should be kept confidential.</p> <p>Record review of the policy Confidentiality of the Resident last review 11/22, documented: Access to any and all computer terminals in facility can be gained only via use of a personal code. Terminal should be shut off when not in use.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</p> <p>Based on observation, interview, and record review, the facility failed to ensure a clean and clutter free homelike environment for two residents (R27 and R88) resulting in soiled and cluttered resident rooms.</p> <p>Finding include:</p> <p>R27</p> <p>Review of the Electronic Medical Record (EMR) revealed, R27 admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness, and history of falls.</p> <p>Review of a Minimum Data Set (MDS) assessment, with a reference date of 5/1/2024 revealed R27 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15.</p> <p>On 4/30/24 at 10 AM R27's room curtain divider was observed soiled with a red stain approximately six by eight inches and a blue fall mat folded in half stored at foot of the bed appeared soiled with numerous cracks in the covering of the mat. When asked how long your bed divider curtain has been stained R27 replied, for a while now.</p> <p>On 5/01/24 at 12:05 PM R27's room curtain divider was observed soiled with a red stain. R27's fall mat was observed soiled with multiple cracks in the covering on the floor next to the bed.</p> <p>On 5/02/24 at 9:03 AM R27's room was observed with Housekeeper M and agreed the bed curtain and floor mat were soiled. Housekeeper M said the curtains are cleaned every two months and that the floor mat should be replaced.</p> <p>On 5/02/24 at 9:30 AM Environmental Supervisor B was interviewed and agreed R27's bed curtain was soiled and needed to be cleaned.</p> <p>On 5/02/24 at 9:36 AM Licensed Practical Nurse (LPN) L agreed R27's fall floor mat was used daily and was soiled and cracked and needed to be replaced.</p> <p>On 5/03/24 at 11:20 AM the Nursing Home Administrator (NHA) was interviewed and agreed soiled items such as curtain dividers and fall mats should be cleaned or replaced timely.</p> <p>15194</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/30/24 at 12:10 PM during an observation of R88's double occupancy resident room. The resident's bed was at the entrance to the room. R88's side of the room had stacks of clutter extending from the entrance of the room around the bed ending onto the pathway of R52's (roommate) bed. The clutter was stacked on the floor approximately 4 feet high. The clutter consisted of soiled clothes, bags of ordered groceries, over the counter medications, blankets, shoes, assistive devices: Walker, Wheelchair, Reacher (used to reach items), a trash can, and assorted cardboard boxes under the foot of the bed. The exposed portion of the floor underneath the bed had a sticky substance that was attracting gnats to the room.</p> <p>On 5/1/24 at 1:10 PM R88 was interviewed regarding the last time her room was cleaned and decluttered. R88 said, Environmental Supervisor (ES) B informed her she had to clean the room herself. R88, stated to the surveyor, I have no way of cleaning the room myself.</p> <p>On 5/3/24 at 9:25 AM during interview with ES B concerning the cleaning of R88's room and removing of the clutter ES B acknowledged the room needed cleaning but was unable to provide an alternate location for the storage of clutter.</p> <p>Review of the Admission Face Sheet documented R88 was admitted to the facility on [DATE], with pertinent diagnoses of Cerebrovascular accident, Diabetes mellitus, Hypertension, and Gastroesophageal reflux.</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R88 was cognitively intact and ambulated with a wheelchair.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</p> <p>Based on interview, and record review, the facility failed to ensure the Preadmission Screening/ Annual Resident Review (PASSAR) forms for Mental Illness/ Intellectual Disability/ Related Conditions Identification (DCH-3877) documents were reviewed, revised, and sent to the local state agency for annual evaluation for a Level II determination for two (R7 and R31) of eight residents reviewed for PASSARs, resulting in the potential for unmet psychosocial care needs.</p> <p>Findings include:</p> <p>R7</p> <p>A review of R7's electronic medical record (EMR) did not reveal a Level II evaluation. There was not a Mental Illness/Intellectual/Developmental Disability/Related condition exemption Criteria Certification (DCH-3878) form. (The DCH-3878 is a State of Michigan Department of Health and Human Services (MDHHS) form used to claim exemption for level II screening). R7 was admitted to facility on 5/25/2018 with most recent readmission on 1/29/2024 with pertinent diagnoses of major depressive disorder, anxiety disorder, and bipolar disorder.</p> <p>Review of a Minimum Data Set (MDS) assessment, with a reference date of 3/8/2024 revealed R7 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15/15.</p> <p>On 5/1/24 at 2:24 p.m., Social Service Director (H) was interviewed and stated, The 3877s were not submitted to the Health Department. The previous social worker was not requesting the Level II evaluation after entering the 3877. I know when the evaluation was done then someone shows up from the health Department. I do not follow up when no one has come to do the evaluation.</p> <p>On 5/03/24 at 11:20 AM the Nursing Home Administrator (NHA) was interviewed and agreed PASARRs should be completed thoroughly and timely.</p> <p>38208</p> <p>R31</p> <p>Record review of R31's electronic medical record (EMR) revealed admission into the facility on [DATE] and readmitted on [DATE] with pertinent diagnoses of bipolar disorder (mental disorder). According to the MDS (Minimum Data Set) dated 1/5/24, R31 had intact cognition with a BIMS of 15/15 and required assistance with ADLS (Activities of Daily Living).</p> <p>Further review of R31's EMR revealed a Level 2 had not been completed on either admission to the facility.</p> <p>Record review of MI-Login- OBRA screen on the Director of Nursing's (DON) computer screen revealed a 3877-78 form had been submitted on 9/22/23.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/3/24 at 1:15PM, DON reported when it was submitted (3877/78), she was not aware that a request for evaluation had to be requested. It was further reported that a follow-up should have been conducted when a level 2 had not been received in a timely manner.</p> <p>Record review of policy PASARR last revised 7/2018, documented: POLICY: Pre-Admission Screening and Resident Review PASARR-GOALS: PASARR will be used on admission as required by the federal government to identify individuals with serious Mental Illness, Mental Retardation, or Developmental Disabilities who are requesting admission to a nursing facility. Further review of policy revealed policy needed to be updated related to changes made in submitting 3877/78 and requesting a Level 2.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230</p> <p>Based on observation, interview, and record review the facility failed to ensure nail care and provide appropriate briefs for incontinence care for four residents (R7, R15, R25, and R128) of 10 reviewed for activities of daily living for dependent residents, resulting in unmet hygiene needs and residnets being left soiled for extended periods of time.</p> <p>Findings include:</p> <p>R128</p> <p>On 4/30/24 at 8:14 a.m. R128 was observed in bed resting. R128 was also observed with scratches on the face (left cheek, forehead, and nose). The resident was asked about the scratches to the face. The resident confirmed the scratches were self-inflicted by accident. R128 was observed with long fingernails (estimated quarter inch long) that appeared to have what looked like dried substance (reddish brown in color) and debris underneath them. R128 stated, They don't cut them unless I ask. I need to get them cut. The resident also confirmed nails are supposed to get cleaned and cut during showers which are once a week per request.</p> <p>On 4/30/24 at 11:28 a.m. review of the clinical record documented R128 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included aphasia, malaise, dysphasia, and cerebral infarction. According to the quarterly Minimum Data Set assessment dated [DATE], R128 had moderate cognitive impairment (BIMS=11) and dependent for all activities of daily living.</p> <p>Review of the ADL care plan did not address nail care.</p> <p>On 5/03/24 at 1:03 p.m. CENA F was interviewed about R128's nail care and said nail care is typically done on shower days. Nail care consist of cleaning underneath the nails and cutting the nails down.</p> <p>On 5/3/24 at 1:15 p.m. the Director of Nursing was interviewed and said nail care is supposed to occur daily and not just on shower days.</p> <p>15194</p> <p>R25</p> <p>On 4/30/24 at 12:30 P.M. during an observation R25 was asked about her care. R25 stated, We are always out of supplies. They have been cleaning us with towels and we never have enough briefs. The aides come and borrow from our packages of briefs to give to somebody else, then when we need to be changed there are none. My roommate (R13) has the same problem. R13 spoke and interrupted the interview commenting, That's right it happens all the time. We have waited as long as five hours before an aide came to see what we needed and, in the meantime, you are wet and sitting in your Bowel Movement (BM), then you hope they find a brief. R25 went on to say there was a shortage of the 2X-large and 3-4 X- large briefs, which she used.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/2/24 at 1:52 P.M. during observation of the supply room on the 200 hall it was noted there were no 2X-large or 3-4 x large briefs in the supply room.</p> <p>In a follow up interview at 2:00 P.M. with unit clerk O (who was identified as being responsible for ordering supplies). Unit Clerk O said orders were made twice a week (Tuesdays and Fridays) and generally an order was submitted for 9-10 cases a week. Unit Clerk O explained the order submitted included: 2X large-9-10 cases, 3-4X -large-8 cases. When asked if the amount ordered changed, Unit Clerk O responded no.</p> <p>On 5/2/24 at 3:40 P.M. the linen cart was checked on the 200 Hall. There were no briefs. In a subsequent visit with R25, the resident was asked if a count could be taken of the number of briefs that were on her dresser. R25 indicated staff just delivered the package and there was a total of 9 briefs, 3X-4X large briefs in the package.</p> <p>On 5/3/24 at 10:00 A.M. R25 was asked if she had any briefs? R25 stated, The aides took them, they borrowed them all, I do not have any. The linen cart was observed on the 200 unit , there were no briefs of any size on the cart.</p> <p>Review of the Admission Face sheet documented R25 was admitted to the facility 6/8/23, with diagnoses of Diabetes Mellitus, Parkinson Disease, Peripheral Vascular Disease, Acquired Absence of Left Leg Above Knee, Tremors and Urinary Tract Infection.</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R25 had a BIMs (Brief Interview for Mental Status) of 14, indicating intact cognition, no behaviors and one-person physical assist to perform Activities of Daily living (ADL's).</p> <p>R15</p> <p>On 5/3/24 at approximately 10:50 A.M., R15 requested an interview regarding briefs. R15 stated, The aides never have enough briefs for the residents. The aides take and X-large brief, (if they can find one) tear the middle from a medium brief and make one for me. I deserve to get a brief that fits! Residents on this 200 hall must wait and then you get a brief that belongs to someone else. Its wrong and I can speak for myself, what about the others that cannot voice their concerns and frustration. It's a problem seven days a week, you can check. R15 then gestured toward the closet, I do not have any briefs, pads, or towels. R15 read from her notes of concerns, I am not a big person, I need a medium brief, I should not have to put on a padded X-large brief all the time. The residents deserve better. R15 indicated other residents had the same or similar problems with the briefs.</p> <p>Review of the admission face sheet documented R15 was admitted to the facility on [DATE] with pertinent diagnoses of End Stage Renal Disease, long term insulin usage and Diabetes. According to the Minimum Data Set, dated dated dated [DATE], R15 had a BIMs (Brief Interview for Mental Status) of 15 indicating intact cognition.</p> <p>47964</p> <p>R7</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/30/24 at 8:31 AM R7 was interviewed about living conditions in the facility and stated, I buy my own briefs and wipes because there aren't enough in the building, I wear size 3 extra-large briefs. The aides tell me there are not enough briefs in my size, so I started to buy my own so that I have some. I have been left wet in a brief several times because there aren't enough briefs in my size.</p> <p>Review of the Electronic Medical Record (EMR) revealed, R7 admitted to the facility on [DATE] with most recent readmission on 1/29/2024 with pertinent diagnoses which included Parkinson's, muscle weakness, and difficulty in walking.</p> <p>Review of a Minimum Data Set (MDS) assessment, with a reference date of 3/8/2024 revealed R7 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15.</p> <p>Review of the care plan dated 2/7/2024 revealed focus Potential/at risk for alteration in skin integrity due to risk factors associated with incontinence (bowel/bladder). Interventions provide peri-care after each incontinent episode and apply barrier cream.</p> <p>On 5/1/24 at 2:13 PM Licensed Practical Nurse L was interviewed regarding 3xl briefs and said extra briefs are kept in the shower room and in the storeroom. There were no 3xl briefs observed in the shower room and no 3xl briefs in the storeroom.</p> <p>On 5/2/24 at 11:35 AM Unit Clerk O was interviewed regarding ordering supplies and said 3xl briefs are ordered on Tuesdays and Fridays, there have been no backorders and deliveries have been consistent on Tuesdays and Fridays.</p> <p>On 5/03/24 at 11:18 AM, the Nursing Home Administrator (NHA) was interviewed and agreed it is the responsibility of the facility to provide adequate supplies for patient care and that residents should not be left wet for extensive amounts of time.</p>

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<p>F 0686</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208</p> <p>Based on observation, interview, and record review the facility failed to consistently administer wound care treatments for one resident (R109) out of three residents reviewed for wound care.</p> <p>Findings Include:</p> <p>During an interview on 4/30/24 at 9:40 AM, R109 reported a sore on the middle of back.</p> <p>Record review revealed resident was admitted into the facility on [DATE] with diagnoses of Idiopathic scoliosis, lumbar region (Curve in spine) and muscle weakness. According to the Minimum Data Set (MDS) dated [DATE], R109 had intact cognition and required extensive assistance with Activities of Daily Living (ADLS).</p> <p>During a wound care observation on 5/2/24 at 11:02 AM, it was observed that resident had a foam dressing on both heels. The heel dressing was dated 4/27/24.</p> <p>During an interview on 5/2/24 at 11:20 AM with LPN N, it was acknowledged that the dressings on R109's bilateral heels were dated on 4/27/24.</p> <p>During an interview on 5/2/24 at 12:40 PM with Licensed Practical Nurse (LPN) S, it was reported that the treatments on R109's bilateral heels were dated 4/27 but were actually done on 4/28.</p> <p>Record review of Treatment Administration Record (TAR) for the month of April 2024, Apply a border gauze or border foam to left heel for protection, every day shift every other day. Start date 1/17/24 at 7:00 AM. This order documented a missed administration on 4/22/24, documentation of wound care on 4/28/24 (dressing was dated 4/27/24), and wound care administered on 4/30/24. Further review of TAR revealed, Cleanse mid back wound pat dry. Apply Medi honey to wound base. Cover with border gauze. Every dayshift for wound care. Start date 4/10/24 at 7:00 AM. This treatment revealed missed administration on 4/13/24 and 4/22/24. Review of right heel order documented: paint right heel with betadine, allow to dry cover with a bulky dressing. Every day shift every other day for wound care. A missed administration was noted on 4/22/24 and it was noted to be administered on 4/30.</p> <p>During a follow-up interview on 5/3/24 at 12:35 PM with LPN N, it was reported that wound care should be administered as ordered by the Physician. Wound care should not be signed off if it was not completed by nursing staff</p> <p>During an interview on 5/3/24 at 3:24 PM with Director of Nursing (DON), It was reported that if a treatment is not signed off it would be considered not done. It was further acknowledged that the treatment signed off on 4/30 could have not been administered if the dressing applied by LPN S was still intact during wound care observation.</p> <p>Record review of policy Dressing Application last reviewed 1/22, documented: ., Document on EHR (Electronic Health Record) or treatment administration record sheet, that dressing was completed.</p>		

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NAME OF PROVIDER OR SUPPLIER Applewood Nursing Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 18500 Van Horn Rd Woodhaven, MI 48183	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38208</p> <p>Based on observation, interview, and record review the facility failed to provide supervision for two unlocked medication carts out of 9 medication carts.</p> <p>Findings include:</p> <p>During an observation on 4/30/24 at 6:30 AM on Station Two, a medication cart for short hall was seen unlocked and no nursing staff in attendance. Medications drawers could be accessed.</p> <p>During an observation on 5/2/24 at 8:45 AM on Station Three, an unlocked medication cart for short hall was seen with medications on top of the cart. This area had approximately 10 residents during the time of the observation.</p> <p>During an interview on 5/2/24 at 8:50 AM with Unit Manager (UM) L, it was reported that medication carts should be locked, and medications should not be left on top of medication carts when a nurse is not in attendance. It was further reported that there could be the potential for residents to ingest medications accidentally.</p> <p>During an interview on 5/2/24 at 1:30 PM with the Director of Nursing, it was reported that all medications carts should be locked when the nurse is not in attendance.</p> <p>Record review of policy Medication Administration last review date 11/2021, documented: .25. Never leave the medication cart open and unattended.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230</p> <p>Based on observation, interview, and record review the facility failed to ensure the foley catheter tubing (a flexible tube for draining urine from the bladder) did not drag along the floor during ambulation in a wheelchair for one (R133) of four residents reviewed for catheter/UTI (urinary tract infection).</p> <p>Findings include:</p> <p>On 4/30/24 at 8:28 a.m. R133 was observed in the dining area of station two, sitting in a wheelchair at the dining table. R133 was observed to have a catheter as evidenced by the catheter tube was on the floor. A staff member came to the dining table, adjusted the catheter bag, but did not adjust the tube that remained on the floor.</p> <p>On 4/30/24 at 9:59 a.m. R133 was observed wheeling independently through the hall of station two with the catheter tubing dragging on the floor. The tubing was observed very close to the front wheel of the wheelchair, placing the tubing at risk to get trapped under the wheel.</p> <p>On 5/03/24 at 11:42 a.m. review of the clinical record documented R133 was admitted into the facility on [DATE] with diagnoses that included obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, and encephalopathy. According to the admission Minimum Data Set assessment dated [DATE], R133 was cognitively impaired, required partial to moderate assistance with activities of daily living care, and able to propel self independently in wheelchair. R133 was also admitted with an indwelling catheter.</p> <p>Review of the care plan for catheter care documented, Resident has an indwelling catheter r/t obstructive uropathy dated 1/31/24. Goal: Resident will remain free of catheter related trauma through next review.</p> <p>On 5/3/24 at 12:55 p.m. Unit Manager G was interviewed and said was uncertain why the tubing was on the floor and the tubing should not have been on the floor. The resident has an anchor but was not certain if not having an anchor would be the reason the tube was on the floor.</p> <p>On 5/3/24 at 1:15 p.m. the Director of Nursing was interviewed and made aware of the catheter tubing. The Director of Nursing said the tubing should never be on the floor.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>15194</p> <p>This citation pertains to intake MI00142960.</p> <p>Based on observation, interview and record review the facility failed to ensure meals were served at a preferred and palatable temperature for four sampled residents (R15, R25, R88 and R90) from a total of 64 residents on the 200 unit, resulting in complaints of cold food and dissatisfaction with meals.</p> <p>Findings include:</p> <p>On 4/30/24 at 9:48 A.M. during a breakfast meal observation residents on the 200 unit were asked about the food. R15, R25, R88 and R90 voiced concerns that their meals were delivered to their rooms and the meals were always cold. During the meal observation entrees were observed delivered from the unit kitchen to residents' rooms without domes or coverings.</p> <p>On 4/30/24 at 9:50 A.M., R15 stated, My Food is always cold. It does not matter what food is served or the meal. The resident explained there was no place to have meals reheated or warmed and other residents had expressed to her the same concern about the food.</p> <p>On 4/30/24 at 9:55 A.M. R88 was asked how was the food? R88 responded the meals were served cold and residents could no longer receive hot dogs or hamburgers. The resident stated when able, food was ordered from the outside.</p> <p>At 10:50 A.M., R90 was observed with an untouched breakfast. The resident was asked about the food and if the meals were served at an acceptable temperature, R90 commented they needed assistance to be fed, but the meals were served cold. The resident stated he frequently asked visitors to bring a sandwich or salad, which was saved for the next day or whenever hungry.</p> <p>On 5/3/24 at 12:01 P.M. during an interview, R15 received two grilled cheese sandwiches. The resident was asked about the temperature. R15 reported an allergy to fish, and the nurse aide had ordered an alternate, but the sandwich was cold. R15 said, It's not hot off the grill as indicated on the ALA Carte Menu. R15 stated, I requested a hamburger but was informed later that's no longer available, I consider the hamburger a hot food item.</p> <p>On 5/3/24 at 1:05 P.M. in the presence of Nurse Aide K the lunch meal tray of R25 was used as a test tray, after the resident said the food was cold and refused to eat the meal. Temperatures obtained were: Breaded fish sandwich- 80.4 Degrees Fahrenheit (D.F.), Orange Drink-54.6 D.F., Jello gelatin- not taken. R25 was quired by Nurse aide K concerning and alternate, but the resident refused stating I am sick of peanut butter, that's cold too.</p> <p>Record review for R15, R25, R88, and R90 revealed the residents were all cognitively intact and had a Brief Intellectual Mental Status (BIMs) of 15/15.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/3/24 at approximately 1:30 P.M., During an interview with Certified Dietary Manager (CDM) A concerning the complaints of cold food, the manager confirmed the facility no longer offered hamburgers on the A'LA Carte Menu. CDM 'A' was unaware of residents complaints of cold food served.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32000</p> <p>Based on observation, interview, and record review the facility failed to maintain sanitary conditions in the kitchen resulting in an increased potential for cross contamination of food and foodborne illness, potentially affecting the facility's total census of 129 residents who receive meal services (7 nothing by mouth residents, or NPO) out of the facility's total census of 136 residents. Findings include:</p> <p>On 4/30/24 at 8:16 AM, at 8:32 AM and at 9:05 AM, Dietary aide, staff C, was observed not using a hand barrier to shut off the faucet when done washing their hands.</p> <p>On 4/30/24 at 8:44 AM, the surveyor requested the facility's hand hygiene policy from Dietary Manager, staff A, to review. At this time the surveyor asked staff A if they had conducted any trainings with staff on the proper procedure to wash their hands to which they stated, yes, upon hire and with the normal reminders every so often.</p> <p>On 4/30/24 at 9:12 AM, Dietary Manager, staff A, was observed not using a hand barrier to shut off the faucet when done washing their hands.</p> <p>On 4/30/24 at 9:37 AM, and at 10:08 AM, Cook, staff E, was observed not using a hand barrier to shut off the faucet when done washing their hands.</p> <p>On 5/1/24 at 9:58 AM, Dietary aide, staff D, was observed not using a hand barrier to shut off the faucet when done washing their hands.</p> <p>On 5/1/24 at 10:18 AM, Dietary aide, staff C, was observed not using a hand barrier to shut off the faucet when done washing their hands.</p> <p>On 5/1/24 at 2:24 PM, upon record review by the surveyor of fifteen separate kitchen policies received, none detailed the hand hygiene expectations for staff working with food in this facility.</p> <p>Review of the U.S. Public Health Service 2017 Food Code, Chapter 2-301.12 Cleaning Procedure, directs that:</p> <p>(C) TO avoid recontaminating their hands or surrogate prosthetic Devices, FOOD EMPLOYEES may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a HANDWASHING SINK or the handle of a restroom door.</p> <p>2. On 4/30/24 between 8:11 AM, and 9:04 AM, upon a facility tour of the three sub-kitchens with Dietary Manager, staff A the following observations were made:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 8:15 AM, scrambled eggs were observed holding at 120 degrees F in the steamwell at sub-kitchen two. At this time the surveyor asked staff A if they could review the sub-kitchen's temperature recording log. At 8:24 AM, upon record review of the sub-kitchen's temperature recording log, both staff A and the surveyor observed temperatures recorded between 120 and 130 degrees F. At this time the surveyor asked staff A if the staff are aware of what the minimum hot holding temperatures of food are required to be at, to which they stated, yes, they do. I don't know why this was missed. I'll talk to them now.</p> <p>At 8:21 AM, hashbrowns were observed by the surveyor, and staff A, holding at 111 degrees F in the steamwell at sub-kitchen one. At this time staff A stated, hashbrowns are always hard to keep temp with out a covering. I'll talk to them about leaving foil on it and rolling it back as they need more product.</p> <p>On 5/1/24 at 12:03 PM, Dietary aide, staff D, was observed plating meals from the steam well for the days lunch service at sub-kitchen two. At this time the surveyor inquired with staff D if they had the opportunity to take temperatures prior to serving to which they replied, no. At this time the surveyor asked staff D if they wouldn't mind taking temperatures before plating the next meal to verify the foods proper holding temperatures to which Dietary Manager, staff A, stated, Why don't I do that so they can keep serving.</p> <p>On 5/1/24 at 12:05 PM, staff A began taking temperatures of food products in the steam well via a thermometer probe revealing a temperature of 117 degrees F for the pureed broccoli. At this time the surveyor asked staff A what they would normally do in a situation like this to which they replied, we'll pull it and reheat it on the stove in the kitchen to 165 degrees F before serving it.</p> <p>Review of 2017 U.S. Public Health Service Food Code, Chapter 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding directs that:</p> <p>(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 57oC (135oF) 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 54oC (130oF) or above; P or</p> <p>(2) At 5 C (41 F) or less. P</p> <p>3. On 4/30/24 at 8:27 AM, Dietary aide, staff C, was observed donning gloves prior to washing their hands after handling refrigerator door handles, touching their face, food containers, and two food preparation counters.</p> <p>On 4/30/24 at 8:52 AM, Dietary aide, staff C, was observed removing their gloves and donning a new pair of gloves without washing their hands.</p> <p>On 4/30/24 at 10:44 AM, the lack of hand washing was observed as Cook, staff E, was observed not washing their hands prior to donning gloves while conducting meal preparation tasks for the days lunch.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/30/24 at 11:40 AM, upon interview with Dietary Manager, staff A, the surveyor inquired what the hand hygiene expectations for staff are when they choose to use gloves as a hand barrier to which they replied, wash their hands before they put them on.</p> <p>On 4/30/24 at 12:00 PM, Dietary aide, staff C, was observed donning gloves after touching food trays, prep counters, the steam table, thermometers, and their clothing prior to handwashing.</p> <p>On 5/1/24 at 12:07 PM, Dietary aide, staff D was observed removing their gloves and donning a new pair of gloves without washing their hands.</p> <p>On 5/1/24 at 2:24 PM, upon record review by the surveyor of fifteen separate kitchen policies received, none detailed the hand hygiene expectations for staff working with food in this facility.</p> <p>Review of the U.S. Public Health Service 2017 Food Code, Chapter 2-301.14 When to Wash directs that:</p> <p>FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLEUSE ARTICLES and:</p> <p>and contamination and to prevent cross contamination when changing tasks;</p> <p>(H) Before donning gloves for working with FOOD; and</p> <p>(I) After engaging in other activities that contaminate the hands.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>32000</p> <p>Based on observation and interview the facility failed to ensure that the garbage storage area was maintained in sanitary conditions resulting in an increased potential for the harborage and feeding of pests. Findings include:</p> <p>On 4/30/24 at 2:18 PM, during a tour of the facility with Environmental Services Director, staff B, the exterior trash dumpsters were observed with lids in the open position, along with a variety of bagged trash and debris in this area. At this time the surveyor inquired with staff B on the current state of the area to which they replied, we can do better. At this time the surveyor asked staff B if the facility had a waste disposal policy to review to which they stated, not that I know of, but I can post a sign to remind people to keep the lids and doors shut.</p> <p>On 5/1/24 at 10:07 AM, during a tour of the facility with Dietary Manager, staff A, the exterior trash dumpsters were observed with lids in the open position, along with a variety of bagged trash and debris in the area. At this time the surveyor inquired with staff A on the current state of the area to which they replied, I think they might have just picked up today, I'm not sure.</p> <p>Review of 2017 U.S. Public Health Service Food Code, Chapter 5-501.113 Covering Receptacles, directs that:</p> <p>Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered:</p> <p>(2) After they are filled; and</p> <p>(B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49103</p> <p>This citation pertains to intake MI00135948.</p> <p>Based on observation, interview and record review the facility failed to post the appropriate directions for isolation care for one resident (R32) of nine residents reviewed for infection control.</p> <p>Findings include:</p> <p>On 4/30/24 at 10:52 AM during observation of R32's door and room it was noted there was a sign hung titled Enhanced Barrier Precautions and with directions for cleansing of hands and for PPE (Personal Protective Equipment) use for anyone providing high-contact resident care activities.</p> <p>On 4/30/24 at 10:54 AM during interview R32 mentioned being in isolation for C. Diff. (Clostridium Difficile is a contagious infection of the large intestine.) According to record review R32's admitted was 4/6/24 and according to a MDS (Minimum Data Set) dated 4/6/24 has a BIMS (Brief Interview for Mental Status) score of 14 indicating intact cognition.</p> <p>On 4/30/24 at 11:15 AM further record review revealed a current physician's order which stated, Contact Isolation. R32 had an order for Vancomycin (an antibiotic) for treatment of Clostridium Difficile to end 5/7/24.</p> <p>On 5/1/24 at 8:25 AM during interview with the Infection Preventionist (IP) P discussion of infection control protocol occurred and the policy was reviewed. The Infection Preventionist acknowledged the physician's order for contact isolation and the policy for Clostridium Difficile isolation which did not match up with the precaution sign on the door of R32's room. The IP P also acknowledged that the facility policy for Clostridium Difficile calls for handwashing with soap and water prior to leaving the isolation room.</p> <p>On 5/2/24 at 8:30 AM a new sign was observed hung on the door for R32's room which stated in part Contact Precautions: Everyone Must: Clean their hands, including before entering and when leaving the room. Next to this note was an image indicating the use of hand sanitizer.</p> <p>On 5/3/24 at 2:00 PM during interview the DON (Director of Nursing) acknowledged the need for appropriate instructions for hand cleansing based on the infection precautions policy.</p> <p>47964</p> <p>On 5/1/24 at 9:00 AM a Contact Precautions sign was observed on R32's door.</p> <p>On 5/01/24 at 12:25 PM, Certified Nursing Assistant (CNA) Q was observed delivering a lunch tray to R32's room. CNA Q was observed walking directly into R32's room and placing lunch tray onto bedside table. CNA Q did not don gloves and or gown prior to entering room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/01/24 at 1:05 PM CNA Q was observed removing lunch trays from residents' rooms and placing items on dirty dish cart. When asked where R32's dirty lunch tray dishes were CNA Q stated I put R32's dishes into the dirty dish cart along with the other residents' dirty dishes and I'm taking them to the kitchen. When asked about R32's contact precautions and how items should be handled CNA Q said R32's dirty dishes should be put in a separate container from other residents' dishes or R32 should use throw away silverware and dishes. CNA Q also said they should don a gown and gloves prior to entering R32's room and should wash hands prior to leaving the room.</p> <p>On 5/2/2024 at 1:00 PM Registered Nurse (RN) P was interviewed and said all staff should wear gowns and gloves when entering a resident room with contact precautions and that R32's dirty utensils, dishes and food trays should be bagged and kept separate from general use to prevent cross contamination.</p> <p>Review of the facility policy Transmission Based/Contact Precautions revised 8/2022 revealed in part .Wear a gown and gloves for all interactions with the patient or potentially contaminated areas in the patient's or resident's environment. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the</p> <p>patient room. Use disposable noncritical patient-care equipment (e.g., blood pressure cuffs) or implement patient dedicated use of such equipment. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient or resident.</p> <p>Review of the facility policy titled Clostridiodes Difficile (formally Clostridium Difficile) with a last review date of 2023 states in part, Following hand hygiene practices, including before seeing a resident and after removal of gloves (with soap and water).</p>