STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235381	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mymichigan Medical Center-Sault	500 Osborn Blvd Sault Sainte Marie, MI 49783

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview and record review, the facility failed to notify, in writing, the resident, resident's representative and a representative of the Office of the State Long-Term Care Ombudsman of the transfer to the hospital for two Residents (#16 and #1) for two residents reviewed for transfers out of the facility. Findings include: Resident #16 (R16) A review of the electronic medical record (EMR) revealed on 9/13/24, R16 was transferred to the hospital and returned 9/16/24. The notification of transfer or discharge to be provided to R16 or their representative, and the notification to the Ombudsman was unable to be located in the EMR. During an interview on 12/4/24 at 11:20 AM, the Nursing Home Administrator (NHA) presented the September Ombudsman transfer log. This log did not list R16. The NHA stated after the change in leadership the notices of transfer had not been done. The NHA also stated the ombudsman log might not be complete and may not include all the discharges. 41978 Resident #1 (R1) Review of R1's EMR progress notes revealed R1 was transferred to the emergency department on 7/29/2024 and admitted to the hospital with discharge back to the facility on [DATE]. Further review of R1's EMR revealed no documentation of notification of transfer or discharge was provided to R1 or their representative. Review of the July 2024 transfer and discharge list provided to the Long-Term Care Ombudsman revealed R1's transfer and hospitalization was not included on the list. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Transfer (Internal and External) and Discharge, last revised 9/2023, revealed the following: Purpose: To ensure residents are appropriately transferred or discharged from the LTC [Long Term Care] . During review of the policy, it was noted the policy included no language or instruction on the provision of notification of transfer or discharge to the resident, the resident's representative or the facility's assigned Long-Term Care Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview and record review, the facility failed to provide written notification of the bed-hold policy to residents or their representatives prior to a hospital transfer for two Residents (#16 and #1) of two residents reviewed for hospital transfers. Findings include: Resident #16 (R16) A review of the electronic medical record (EMR) revealed on 9/13/24, R16 was transferred to the hospital and returned 9/16/24. The EMR revealed no documentation indicating R16 or their representative was provided information on the facility bed hold policy or agreement at the time of transfer or after hospitalization . During an interview on 12/4/24 at 11:20 AM, the Nursing Home Administrator (NHA) stated the bed hold policy was not reviewed with the resident or the responsible party at the time of transfer. 41978 Resident #1 (R1) Review of R1's EMR progress notes revealed R1 was transferred to the emergency department on 7/29/2024 and admitted to the hospital with discharge back to the facility on [DATE]. Further review of R1's EMR revealed no documentation indicating R1 or their representative was provided information on the facility bed hold policy or agreement at the time of transfer or after hospitalization . Review of the facility policy titled, Transfer (Internal and External) and Discharge, last revised 9/2023, revealed the policy did not include any language or instruction related to the provision of bed hold agreement before or upon transfer out of the facility.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to physically assess an acute change in condition and failed to timely identify and treat constipation for one Resident (#18) of one resident reviewed for change in condition, resulting in abdominal discomfort, nausea, and the potential for worsening of medical condition and complications of constipation. Findings include: Resident #18 (R18) Review of R18's Minimum Data Set (MDS) assessment, dated 10/23/2024, revealed admission to the facility on [DATE] with diagnoses including peripheral vascular disease, Type 2 diabetes mellitus with hyperglycemia, left above the knee amputation and gangrene (tissue death from infection or lack of blood flow) of the right foot. Further review of the MDS assessment revealed R18 was cognitively intact and required extensive/maximal assistance with transfers and toileting. On 12/2/2024 at 10:13 a.m., R18 was observed seated in bed, holding a tissue to her mouth. Further observation revealed a green emesis bag on top of the over bed table positioned in front of R18 in bed. R18 was observed, diaphoretic (sweating) with a pale color. R18 reported she was nauseous and had been vomiting that morning. R18 was unable to continue the interview and requested privacy. During an interview on 12/2/2024 at 12:40 p.m., Licensed Practical Nurse (LPN) G reported being aware R18 was nauseous and had been vomiting that morning. LPN G reported she was unsure why R18 was not feeling well. A review of R18's electronic medical record (EMR) conducted on 12/2/2024 at 11:20 a.m. and 12/4/2024 at 10:15 a.m. No documented physical assessment of R18 was observed, including checking the resident for fever, bowel sounds and assessment of the abdomen or blood glucose evaluation on 12/2/2024 to correspond with the Resident's condition. Further review of the EMR revealed no documentation of physician notification related to R18's condition or nausea and vomiting on 12/2/2024. During an interview on 12/4/2024 at 10:55 a.m., the Director of Nursing (DON) reported nursing staff informed her they believed R18's nausea and vomiting on 12/2/2024 was related to constipation, and therefore the physician was not notified because the facility had standing orders for bowel care. The DON stated nursing staff should have conducted a physical assessment and blood glucose check in response to R18's condition on 12/2/2024. The DON reviewed R18's record at the time of the interview and confirmed no physical assessment or blood glucose check was documented for R18 for the timeframe of 12/2/2024 through the date and time of this interview. The DON confirmed nursing assessment is a standard of practice and should be conducted to promptly identify potential complications related to illness and change in condition. Review of the facility's, Admission Standing Orders, for bowel care, presented by the DON, revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A) Colace 200 mg [milligram], by mouth every PM; B) Milk of Magnesia 30 ml [milliliter] by mouth at bedtime on day 2, without BM [bowel movement] or as needed; C) Bisacodyl suppository in AM on day 3 without BM; D) Fleet enema if no BM 1 hour after suppository; E) Soap suds enema day 4, without BM. Review of R18's EMR including point of care documentation titled, B&B - Bowel Elimination, for November and December 2024 revealed documentation R18 had no bowel movements from 11/18/2024 at 2:54 a.m. until 11/24/2024 at 5:59 a.m. (approximately 6 days). Review of R18's November 2024 Medication Administration Record (MAR) revealed the bowel care standing orders were not implemented until 11/23/2024 at 8:34 a.m. with administration of a dose of Milk of Magnesia 30 ml., more that five days after R18's last bowel movement. It was noted there were no documented refusals of bowel care for R18 from 11/18/2023 through 11/24/2024 in the EMR or included on the November 2024 MAR. It was also noted there was no documentation of physician notification of the Resident's condition during the referenced timeframe. Review of R18's progress notes revealed the following: 11/23/2024, 18:33 [6:33 p.m.], Resident complaining of stomach pain [related to] constipation. MOM [Milk of Magnesia] administered as directed with noted results. Further review of R18's point of care documentation for B&B -Bowel Elimination, revealed the Resident did not have a bowel movement recorded from 11/30/2024 at 2:00 p.m. until 12/03/2024 at 3:41 p.m., a timeframe of more than three full days with no bowel movement. Review of R18's December 2024 MAR revealed no initiation of bowel protocol or documented refusals during the three-day period R18 did not have a bowel movement.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to ensure appropriate feeding assistance for one Resident (#20) of one resident reviewed for nutrition, resulting in the potential for decreased intake and weight loss. Findings include: Resident #20 (R20) A review of R20's Minimum Data Set (MDS) assessment, dated 11/6/2024 revealed R20 was admitted to the facility on [DATE] and had diagnoses including dementia and arthritis. Further review of the MDS assessment revealed R20 had severe cognitive impairment. Review of R20's, Medical Nutrition Therapy Assessment, completed by Certified Dietary Manager (CDM) C on 11/11/2024 at 2:49 p.m. revealed R20 had a history of weight loss/underweight BMI [body mass index]. Further review of the Assessment reviewed the following: . verbal reports from CNA [certified nursing assistant] and NSG [nursing] indicate signs resident may need increased cueing and assistance [related to] gradual cognitive decline and increased dexterity/pain [related to] rheumatoid arthritis . Staff advised to encourage resident to dine in MDR [main dining room] for increased monitoring, cueing, and assistance when needed. Review of R20's care plan revealed the following: The resident has potential nutritional problem [related to]: cachexia [weight and muscle loss] . chronic poor intake . [history] of weight loss . Interventions: Assist needed for meals/snacks: At minimum needs set up assist + [plus] supervision [due to] food hoarding tendencies and/or disposing of food in inappropriate places. Due to progressing arthritis and cognitive decline, may need cuing and limited assist at times . encourage resident to dine in MDR to better monitor for increase assistance needs . Encourage intake and all nutritional interventions in place. On 12/2/2024 at 12:57 p.m., an unidentified staff person was observed delivering R20's noon meal tray to the Resident's room. R20 was observed in the room, sleeping in her wheelchair. Upon setting the meal tray down, two foam cups with lids and two unopened straws atop the over bed table were positioned approximately three feet from where R20 was sleeping, the unidentified assistant left the room and R20 remained sleeping. Further observation at 1:08 p.m. revealed R20 still asleep in her wheelchair and her meal untouched with the unopened straws resting on the over bed table near the two foam cups filled with liquids. An observation of the tray card on R20s meal tray revealed the following: Alerts: encourage eating in MDR for [greater] assistance. Needs cueing [and] assist during meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/2024 at 1:23 p.m., R20 was observed awake, still seated in her wheelchair approximately three feet from the over bed table and meal tray. R20 was pleasantly confused and when asked if she was going to eat her meal she stated, I'm going to try. Upon exiting R20's room, two unidentified staff members were observed approaching R20's doorway, and from the hallway, asked R20 if she was finished with her meal to which R20 was heard replying, I haven't even started yet. The two staff members told R20 they would check back later and then left R20s doorway and continued down the hall. Further observation on 12/2/2024 at 1:50 p.m. revealed R20 seated in a wheelchair in her room with the meal tray still atop her over bed table with all food remaining untouched and the drinks still covered and without the straws inserted. The two straws remained unopened and sitting on the table next to the drinks. At that time, CNA H and CNA I entered R20's doorway and asked R20 if she was finished with her meal. R20 responded I haven't even started. Neither CNA H or CNA I entered R20's room to provide cueing or assist with her meal before leaving the doorway and continuing down the hall. On 12/4/24 at 9:03 a.m., R20 was observed sitting in her bed. A plate with one-half slice of toast, a full bowl of sausage pieces and a full bowl of scrambled eggs were positioned in front of R20 on an over bed table. Both the sausage and the eggs appeared untouched. When asked if she was going eat her meal, R20 responded, oh, I don't know. There were no staff present in R20's room at the time of the observation. During an interview on 12/4/24 at 2:02 p.m., CDM C reported R20's progressive dementia puts her at risk of decreased dietary intake and weight loss. CDM C confirmed R20 required cueing and assistance with meals and stated she was unaware R20 was not receiving assistance with meals when the Resident was served in her room. CDM C reported R20's dietary intake improved greatly with assistance and cueing. CDM C stated R20 had cognitive decline and difficulty with arthritis in her hands which made eating difficult at times. Review of the facility policy titled, Feeding the Resident on Long Term Care, last revised 9/2023, revealed the following: Purpose: To assist the patient/resident who is physically, medically or cognitively unable to feed themselves. Further review of the policy revealed no language or instruction related to feeding assistance provided per the CDM recommendations or the resident's person-centered care plan.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41978 Based on observation, interview and record review the facility failed to ensure a medication error rate less than five percent for 1 Resident of 4 residents reviewed for medication administration, resulting in 2 observed medication errors out of 25 opportunities, and a medication error rate of eight percent. Findings include: Resident #26 (R26) On 12/4/2024 at 8:37 a.m., Licensed Practical Nurse (LPN) J was observed preparing a dose of insulin from a Humalog Kwikpen (rapid-acting insulin pen) for administration to R26. Prior to dialing the prescribed dosage in the pen, LPN J primed the pen needle by dialing two units, holding the pen horizontally with the needle pointed sideways, and depressing the dose knob to release the insulin into the needle. LPN J then dialed the pen to deliver 13 units for administration, as prescribed. LPN J reported R26 was also due to receive 25 units of long-acting insulin. After attaching the needle to R26's Lantus Solostar (long-acting insulin pen), LPN J dialed two units and proceeded to prime the needle by depressing the dose knob to release the insulin with the pen held horizontally and needle pointed sideways. LPN J then dialed the pen to deliver the prescribed 25 units of Lantus. Immediately following preparation of R26's medication, LPN J was observed administering R26's Lantus insulin into his left lower abdomen. After depressing the dose knob to release the 25 units of insulin, LPN J immediately removed the needle from the resident. LPN J then administered R26's Humalog insulin into his right lower abdomen. After depressing the dose knob to release the 13 units of insulin, LPN J held the needle in place for three seconds before removing the needle from the resident. During an interview immediately following the observation, LPN J acknowledged priming both insulin pens with the pens held horizontally and needles pointed sideways. LPN J also stated she was aware she did not hold the needles in place for any more than three seconds after pushing the dose knobs on the pens to release the insulin. Review of the manufacturer's recommendations for use of the Humalog KwikPen, accessed on 12/5/2024 and last revised 7/2023, revealed the following: . Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use . To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with the needle pointing up. Push the dose knob in until it stops. Giving your injection: Insert the needle into your skin. Push the Dose Knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle. Review of the manufacturer's recommendation for use of the Lantus Solostar, accessed on 12/5/2024 and last revised 8/2022, revealed the following: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Step 3. Perform a safety test: Dial a dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle . Step 5. Inject your dose: Keep the pen straight, insert the needle into your skin. Use your thumb to press the injection button all the way down. When the number in the dose window returns to [zero] as you inject, slowly count to 10 before removing. Counting to 10 will make sure you get your full insulin dose.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 40383 Based on observation, interview, and record review, the facility failed to ensure therapeutic diets were served as prescribed for three Residents (#14, #26, and #34) of six residents reviewed for therapeutic diets. This deficient practice resulted in the potential for health complications and contributed to an inability for residents to meet their goals. Findings include: Resident #14 (R14) On 12/2/24 at 12:46 PM, R14 was observed in the facility dining room eating lunch. The meal tray card for R14 read: Special Diets: Low Sugar ~Thin Liquids and Standing (order): 1/2 (one half) portion desserts. R14 had received two oatmeal raisin cookies. The Certified Dietary Manager (CDM) C observed the meal. When CDM C observed two cookies were served to R14 (the standard portion size), and the meal tray card instructions indicated 1/2 portion dessert, CDM C stated, That is incorrect. The resident should have received one cookie. The resident was observed eating both cookies. A review of the Electronic Medical Record (EMR) for R14 revealed Diet order: Low Sugar diet, IDDSI (International Dysphagia Diet Standardization Initiative) Regular/Easy to Chew (Level 7) texture, IDDSI Thin (Level 0) consistency, prescribed on 4/1/2024. The care plan for R14 included a focus of: The resident has potential nutritional problem r/t (related to): *Medical/Physical conditions - Obesity: may have intake in excess of metabolic needs . DM (diabetes) . *Diet .Therapeutic diet order r/t DM *Weight . -Anticipate beneficial wt (weight) loss d/t (due to) resident goal weight . Date Initiated: 4/1/2024 Revision on: 11/6/2024 Approaches for this care plan problem included: *Diabetic . *Provide diet as ordered: Low sugar; Level 7/Easy to chew Level 0/Thin liquids *Requests small portions and 1/2 portion of desserts . *Request & honor menu selections while adhering to/encouraging ordered diet. *Provide positive reinforcement for compliance with diet: -Provide and encourage low sugar/calorie snacks . (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assist resident as needed in choosing appropriate portions. *Preferred portion size: Small Date Initiated: 04/01/2024 Revision on: 08/05/2024 The nutritional assessment written 11/6/2024 included, Staff to continue encouraging low sugar food/fluid choices and provide all interventions in place. Resident #26 (R26) On 12/2/24 at 12:21 PM, R26 was eating lunch in the facility dining room and had chosen to eat his two oatmeal raisin cookies first. R26's meal tray card indicated a Special Diet: Low Sugar, ~Thin Liquids (Level 0). Another section of the tray card read Caution with sugar/carbs (carbohydrates)! CDM C observed this meal and was asked what the caution statement meant. CDM C said a low sugar diet should receive half portions of the dessert and explained the portion size with this meal was one cookie rather than two. The CDM said the servers should have only served one cookie to R26. A review of the EMR for R26 revealed a Diet order of Low Sugar diet, IDDSI Regular (Level 7) texture, IDDSI Thin (Level 0) consistency, prescribed on 4/1/2024. The care plan for R26 indicated a focus of: The resident has potential nutritional problem r/t: *Medical/Physical conditions -Dementia dx (diagnosis); has confusion/memory deficits. May have decreased interest in food, appetite changes, and/or changes in food preferences. May struggle to recognize food/beverages, and/or be unsure how to feed self. -DM type 1; not well controlled at times. *Diet: -Therapeutic diet order r/t DM type 1. -Hx (history) of poor intake. *Weight: -Recent significant unintended weight gain . Care Plan approaches included: *Diabetic . *Provide diet as ordered: Low sugar; Level 7/Regular; Level 0/Thin liquids. Date Initiated: 04/01/2024 Revision on: 11/25/2024 Resident #34 (R34) On 12/4/24 at approximately 1:15 PM, R34 was observed in her room eating lunch. Her tray card indicated a Low Sugar diet with regular texture and regular thin liquids and instruction to serve 1/2 portion of dessert. R34 received a full serving of cherry pie. The EMR for R34 included a diet order of: Low Sugar diet, Regular (Level 7) texture, Thin (Level 0) consistency, prescribed on 11/6/2024. The care plan for R34 included a focus of: (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R34) has nutritional problem or potential nutritional problem related to: * Medical/Physical conditions -Recent CVA (cerebrovascular accident)/TIA (transient ischemic attack) [stroke/stroke like symptoms] w (with)/mild L (left) side weakness. -Generalized weakness.-FTT (failure to thrive) diagnosis. -DM (diabetes) type 2. -Macular degeneration; highly impaired vision. *Diet -Restrictive therapeutic diet order .-Poor intake at times . Date Initiated: 11/13/2024 Revision on: 12/04/2024 The care plan interventions included: Provide diet as ordered: Low Sugar; Level 7/Regular textures;Level 0/Thin liquids. During an interview on 12/3/24 at 12:04 PM, CDM C stated the facility used a very liberalized diabetic diet and provided the LTC (Long Term Care) Therapeutic diet descriptions/definitions guide. The low sugar diet was defined in this guide as: No added sugar; 1/2 portion dessert. CDM C indicated the food servers should be serving 1/2 portion of desserts to those on the low sugar diet. During the lunch meal observation on 12/4/24 at 12:15 PM, the dessert of the meal was cherry pie served in clear bowls. R14, R26, and R34 were observed receiving the same size portion of cherry pie dessert as other residents. On 12/4/24 at approximately 12:30 PM, an interview was conducted with Dietary Staff E who was serving in the facility dining room. Staff E pointed out he was serving a cherry pie for dessert. Staff E said, All of the desserts are the same. When asked if residents on the low sugar diets were getting 1/2 portion of the dessert, Staff E replied, No.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 40383 Based on observation, interview, and record review, the facility failed to provide dining adaptive equipment for four Residents (#26, #23, #3, and #24) of 6 residents reviewed for dining assistive devices. This deficient practice resulted in increased difficulty with food consumption and independent eating, as well as the potential for decreased food/fluid intake and risk for weight loss. Findings include: Resident #26 (R26) On 12/2/24 at 12:21 PM, R26 was eating lunch in the facility dining room and was observed with regular utensils including a knife, fork, and spoon. R26's meal tray card included Adaptive Equip: No Knives/cut food as needed for resident. Certified Nurse Aide (CNA) K approached the resident and removed the knife without explanation. When questioned CNA K was not sure why the resident could not have knives. A review of the electronic medical record (EMR) for R26 revealed a care plan including a focus of: The resident has potential nutritional problem r/t (related to): Medical/Physical conditions -Dementia dx (diagnosis); has confusion/memory deficits. May have decreased interest in food, appetite changes, and/or changes in food preferences. May struggle to recognize food/beverages, and/or be unsure how to feed self. Care Plan approaches included:*Adaptive equipment/modifications: -No knives; all food in bite-size pieces. *Assist needed for meals/snacks: Usually independent; may need set-up assist & supervision at times .Date Initiated: 04/01/2024 Revision on: 11/25/2024 Resident #23 (R23) On 12/3/24 at 8:40 AM, R23 was observed eating breakfast on a regular plate and was eating unassisted with her fingers. R23's meal tray card included instructions for: Adaptive Equip: . Divided plate . CNA D stated R23 did well attempting to feed herself and said a divided plate helped her. The care plan for R23 included a focus of: The resident has potential nutritional problem r/t: *Medical conditions -Dementia; has frequent confusion and memory deficits; may have decreased interest in food, appetite changes, and/or changes in food preferences. May be unsure how to feed self .*Diet:-Poor appetite at times. *Weight:-Hx (history) of significant weight loss .Date Initiated: 04/01/2024 Revision on: 11/18/2024. The care plan approaches included: Offer to make meal into a sandwich; resident prefers finger food . Date Initiated: 04/01/2024 Revision on: 11/18/2024 Resident #3 (R3) On 12/4/24 at 12:41 PM, R3 was eating her lunch in the dining room. Her meal included two coffee cups and water in a Styrofoam cup. All beverages were uncovered. There was a lid sitting on the table. The meal tray card for R3 included instructions of: Adaptive Equip: Cup w (with)/lid (with lid) . CNA D said the tray card has instructions that lids were needed and they should have been on the beverages. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for R3 included a focus of: The resident has potential nutritional problem r/t: Medical/Physical conditions -Dementia and hx of traumatic brain injury; has confusion & memory deficits .Intake: -Hx of poor frequent poor appetite . Date Initiated: 04/01/2024 Revision on: 10/15/2024 The care plan approaches included: .Adaptive Equipment/Modifications: -All beverages in cup w/lid . Date Initiated: 04/01/2024 Revision on: 10/15/2024 Resident #24 (R24) On 12/4/24 at approximately 1:00 PM, R24 was observed eating lunch in her room. R24 had a small plastic fork as her only utensil. R24 stated, I can't eat that well with a plastic fork and I really need a spoon for my dessert. The meal tray card did not indicate plastic utensils were needed for R24. During an interview in the serving area on 12/4/24 at approximately 1:10 PM, Dietary Staff E and CNA D were asked about R24's utensils and stated, We ran out of forks. They only could find a soup spoon left to deliver to R24. The staff members stated they gave out plastic forks to approximately 6-8 of the last trays served.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety as evidenced by: A. Failing to ensure that food items were kept free from contamination due to improper storage or due to potential thawing and refreezing. B. Failing to properly clean and sanitize dishes and utensils. C. Failing to ensure food preparation surfaces in the dietary department were properly sanitized. D. Failing to ensure that food items were dated and discarded on or before the expiration date. This deficient practice had the potential to result in food borne illness among any or all 35 residents in the facility. Findings include: During a tour of the kitchen with Registered Dietitian (RD) A on [DATE] at 10:00 AM, a walk-in freezer (#2) had no internal thermometer and large chunks of ice had formed on the floor of the freezer under the condenser. RD A stated there was a work order to look at this problem. There was evidence of ice cascades on food product under the condenser. RD A stated this condition was not optimum and said, The (food) product is not protected. The temperature log for freezer #2 was reviewed for the month of November and was found to have 8 days with no temperatures recorded. The tour continued and the back walk-in freezer (#5) also had no internal thermometer and had a large chunk of ice formed on the ceiling and ice on the floor. A steam table pan of uncovered cooked rice was on a cart directly under the condenser. The cart had a frozen puddle of clear liquid on the top shelf next to the open rice pan. Another cart was observed in this freezer (#5) with 6 small, uncovered steam table pans of marinara sauce and 6 small, uncovered steam table pans of chili on its top shelf. The temperature log for freezer #5 was reviewed for the month of November and was found to have 9 days with incomplete documentation and 8 days with no temperatures recorded . With the presence of ice cascades and freezer temperatures not being consistently monitored for safety, it could not be concluded the food had not had periods of thawing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The tour continued and observations were made of the three-compartment sink which was operational with all three sinks filled and being used to wash, rinse and sanitize food contact surfaces of utensils, pans, and lids. An interview to determine the procedure for testing the sanitizing chemicals was conducted at this time with dietary Staff B. A demonstration by Staff B using a QT40 (sanitizer level) test strip held in the sanitizing solution for 10 seconds took place. The strip was compared to the dispenser and had a color corresponding to 0 ppm (parts per million) signifying no sanitizer was present in the sink. Staff B indicated the test strip should be 200 ppm. RD A was also present. Staff B tested the solution twice and then opened a spool of new test strips, but all test strips registered zero ppm. The sanitizing bucket used to sanitize food preparation surfaces was observed on the counter with cleansing cloths floating in the solution. This bucket was tested and registered 0 ppm indicating sanitizer was not present. During a tour of the Long Term Care satellite kitchen on [DATE] at 10:23 AM, the service area reach-in freezer was observed to contain: - Unlabeled, open to air, meat patties without a date of preparation or a use by date - An unsealed plastic bag labeled beef hot dogs dated ,d+[DATE], open to air - Omelets with unreadable marking on the plastic bag without a use by date - Unlabeled potato patties with unreadable marking on the plastic bag. On [DATE] at 11:08 AM, the Director of Nursing (DON) observed the above food items in the freezer and said Yes I can't tell the dates. I will alert dietary. On [DATE] at 10:42 AM, the dietary walk-in freezer #5 continued to have ice remaining on the floor and on food packaging. Items under the condenser had evidence of ice on the outer packaging including pita bread with a hole ripped in the top of the package. Walk-in freezer #2 also continued to have ice remaining on the floor and contained a foil steam table pan labeled chopped steak ,d+[DATE] which was observed open to air and was located under the condenser unprotected. The facility policy titled Floor Supplies/Nursing Pantries/Food from an Outside Source Policy dated as last revised ,d+[DATE] read in part: .All perishable and nonperishable items .delivered to the floor are labeled and have an expiration date, after which the item is to be removed and discarded .Expired, out-of-date, opened or uncovered, unlabeled and improperly stored items are discarded .Temperatures of patient refrigerators are recorded daily by food service staff on a refrigerator log . The FDA Food Code 2017 States: - ,d+[DATE].11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- ,d+[DATE].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 ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO_EAT, 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 [Celsius] (41 F [Fahrenheit]) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 - ,d+[DATE].11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].14 Wiping Cloths, Use Limitation. (A) Cloths in-use for wiping FOOD spills from TABLEWARE and carry-out containers that occur as FOOD is being served shall be: (1) Maintained dry; and (2) Used for no other purpose. (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S ,d+[DATE].114; - ,d+[DATE].114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization -Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ,d+[DATE].11(C) shall meet the criteria specified under S,d+[DATE].11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: .C) A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24 C (75 F), P (2) Have a concentration as specified under S ,d+[DATE].11 and as indicated by the manufacturer's use directions included in the labeling, P and (3) Be used only in water with 500 MG [milligrams]/L ([liter] hardness or less or in water having a hardness no greater than specified by the EPA-registered label use instructions; - ,d+[DATE].11 Before Use After Cleaning. UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40383 Based on interview and record review, the facility failed to ensure that a Quality Assurance and Performance Improvement (QAPI) program committee was composed of the required committee members. This deficient practice resulted in the potential for ineffective coordination of medical care and delayed resolution of facility issues placing all 35 residents of the facility at risk for quality care concerns. Findings include: During an interview on 12/4/24 at 3:10 PM, the Nursing Home Administrator (NHA) stated the QAPI committee previously met quarterly and now met monthly. The NHA reviewed the Long Term Care (LTC) QAPI Sign In or meeting attendance records for the required members and identified the following: - On 2/15/24 the QAPI meeting included the NHA, the Director of Nursing (DON), the Medical Director, the Infection Preventionist (IP), plus 3 other members. - The next record of a QAPI meeting was not until 6/20/24 which included the NHA, the DON, the IP, plus 5 other members. The Medical Director was not in attendance. - On 7/18/24 the QAPI meeting was held and included, the DON, the IP, plus 4 other members. The Medical Director and the NHA were not in attendance. - On 8/15/24 the QAPI meeting was held and included the required members. - On 9/19/24 the QAPI meeting was held and included the NHA, the DON/IP, plus 3 other members. The Medical Director was not in attendance. - On 10/17/24 the QAPI meeting was held and included the NHA, the DON/IP, plus 3 other members. The Medical Director was not in attendance. - On 11/14/24 the QAPI meeting was held and included the required members. The facility policy Quality Assurance Performance Improvement Program - LTC was dated as last revised 9/2023 and read in part, QAPI members required at each meeting include: LTC Medical Director, Director of Nursing, Member of Management, three other employees, minimum. The policy did not include the requirement of the infection preventionist attending the QAPI meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to ensure the use of enhanced barrier precautions (EBP) during wound care according to the physician's order and current standards of practice for one Resident (#15) of two residents reviewed for wound care, resulting in the potential for the spread of multidrug-resistant organisms (MDROs). Findings include: Resident #15 (R15) Review of the Minimum Data Set (MDS) assessment, dated 10/30/2024, revealed R15 was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia, diabetes, bullous pemphigoid (an autoimmune disease causing large, fluid-filled blisters), and a stage two pressure injury (partial thickness loss of tissue) to the right buttock. On 12/2/2024 at 9:37 a.m. a sign indicating the use of enhanced barrier precautions (EBP) for all high-contact care activities, was observed attached to the left side of R15's doorway. The sign stated, Everyone Must: . Wear gloves and a gown for the following high-contact resident care activities . Wound Care: any skin opening requiring a dressing . Wound care was observed performed by Licensed Practical Nurse (LPN) G with assistance from Certified Nursing Assistant (CNA) I on 12/03/2024 at 2:35 p.m. An open wound was observed on R15's right buttock. LPN G stood on the right side of R15's bed to deliver care and CNA I was observed standing on the left side of the bed to assist in positioning R15 on her left side during wound care. LPN G and CNA I were not wearing protective gowns during the observation of the R15's wound care. During an interview, immediately following the wound care observation, LPN G was asked about the sign indicating use of EBP during high-contact care attached to R15's doorway. LPN G reported she was unaware of the need for EBP during wound care for R15. Review of R15's electronic medical record (EMR) revealed the following active physician's order: Enhanced barrier precautions; follow higher level precautions, if ordered, every shift for wounds . Order Dated: 5/20/2024. Review of R15's care plan revealed the following: Impaired skin integrity due to bullous pemphigoid . Stage 3 pressure injury (history of reopening). Date initiated: 4/01/2024 . Interventions . Use of enhanced barrier precautions with any high-contact resident activity. Date Initiated: 10/16/2024. Review of the Centers for Disease Control and Prevention (CDC) guideline titled, Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/02/2024, revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization .