STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235405	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clinton Twp	17001 17 Mile Rd Clinton Township, MI 48038

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on interview and record review, the facility failed to ensure an Advanced Directive was in place timely for one (R73) of four residents reviewed for Advance Directives (AD-legal documents that allows a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility or other healthcare providers. Findings Include: Review of electronic health record (EHR) on [DATE] at 1:23 p.m. revealed R73 did not have a code status in the banner or a signed advance directive form. Review of an Admission Record revealed, R73 originally admitted to the facility on [DATE], and readmitted on [DATE] with pertinent diagnosis which included End Stage Renal Disease and Type 2 Diabetes. Review of a Minimum Data Set (MDS) assessment dated of [DATE] revealed R73 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 15 out of 15 and required dialysis. On [DATE] at 8:48 a.m., an Advance Directive was requested for R73. Review of an advance directive dated [DATE] revealed, R73 elected CPR (Cardiopulmonary resuscitation) and yes to all treatment. In an interview on [DATE] at 1:52 p.m., Social Worker (SW) L reported an advance directive should be completed by day three of admission. SW L the reported the AD for R73 was completed today ([DATE]). SW L then reported R73 should have had an advance directive completed prior to today. Review of an Resident's Rights Regarding Treatment and Advance Directives policy revised ,d+[DATE] documented the following: Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive . 1. On admission, the facility will determine if the resident has executed an advance directive . and if not, determine whether the resident would like to formulate an advance directive .

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview, and record review, the facility failed to initiate a care plan for a newly identified facility acquired pressure ulcer for one resident (R441) of four residents reviewed for pressure ulcers. Findings include: On 4/23/24 at 9:26 AM, R441 was observed in bed lying on their backside, face grimacing and indicating that they were in pain. On 4/23/24 at 11:37am and 2:23pm, R441 was observed in the same position as they had been earlier that morning. A review of R441's medical record revealed that they were admitted into the facility on [DATE] with diagnoses that included Paroxysmal Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, and Depression. Further review of the medical record revealed that the resident was severely cognitively impaired and required total dependence for Activities of Daily Living. Further review of the wound doctor's Visit report for 4/12/24 revealed the following, Wound #1 Sacral is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not healed.Sequela wound encounter measurements are 2.2cm (centimeters) length x 2cm width x 0.5cm depth, with an area of 4.4 sq cm (square centimeters) and a volume of 2.2 cubic cm A review of R441's care plan revealed the following, Focus: I am at risk for impaired skin integrity r/t (related to) incontinence. Date initiated: 03/05/2024 . Interventions/Tasks: Assist me to moisturize my skin as needed. Date Initiated: 03/05/2024. Incontinent: Cleanse area and apply barrier cream to buttock/peri area after incontinence episodes, per my preference and as I permit. Date initiated: 03/05/2024 . Further review of the care plan did not reveal a care plan addressing R441's newly acquired pressure ulcer. On 4/25/24 at 2:04 PM, an interview was completed with the Director of Nursing (DON) regarding the lack of implementation of care planned interventions, and she explained that the care plan should reflect the resident's current status. A review of the facility's Skin and Pressure Injury Risk Assessment and Prevention policy revealed the following, 12. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors indemnified in the risk assessment, skin assessment, and any pressure injury assessment .

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. 46956 This citation pertains to Intake M100143094. Based on interview and record review, the facility failed to provide adequate, meaningful weekend activities for facility residents including eight anonymous group participants. Findings include: On 04/24/24 at 2:29 PM, eight anonymous group participants indicated the facility no longer had activities department staff working on the weekends and no organized or meaningful activities were being provided or facilitated. The group participants reported being bored and having nothing to do on weekends. Review of the facility Activities calendar for March and April 2024 revealed all Saturdays stated Independent leisure activities can be found in the dining room and all Sundays stated 10 AM Independent activity and 1:30 PM Afternoon Worship. On 04/25/24 at 9:37 AM, the facility Activities Director (AD) reported the facility no longer employed Activities aides. The AD reported they work a full time day shift schedule and therefore there are no dedicated Activities department employees scheduled on weekends. The AD reported they set up items (board games, coordination games, etc.) in the dining room for residents to use on weekends and the Certified Nursing Assistants (CNAs) and other staff can assist residents to access these items. On 04/25/24 at 1:30 PM, the facility Administrator (NHA) reported the facilities Activities aides positions were eliminated and verified that there are no dedicated Activities department staff scheduled on weekends. The NHA reported in response to these staffing changes the facility has instructed other facility staff such as CNAs and nurses to assist in facilitating activities on the weekends. On 04/25/24 at 2:29 PM, the NHA reported their expectation was non-Activities department staff such as CNAs and nurses would be able to satisfactorily assist residents to participate in meaningful weekend activities in a manner that was not insufficient compared to weekday Activities programming. Review of the facility policy Activities dated 01/01/24 revealed the Policy statement It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 46956 Based on interview and record review, the facility failed to ensure the Activities Director met the required professional qualifications. Findings include: On 04/25/24 at 9:37 AM, the facility Activities Director (AD) was interviewed and reported they had been in the AD position for approximately one month. The AD reported they are a Physical Therapy Assistant (PTA) and they had been working in the facilities therapy department prior to accepting the AD position. The AD reported they planned to take college classes to pursue Therapeutic Recreation-related credentialing but they were not currently participating in this training/education. On 04/25/24 at 1:06 PM, the AD reported they transitioned directly from the therapy dept. to the AD position and they did not have recent/previous experience in an Activities department. On 04/25/24 at 1:30 PM, the facility Administrator (NHA) acknowledged the current AD did not meet the required professional qualifications. The NHA reported the facility had provided the AD with the resources to pursue their credentialing for the position and arranged for the AD to receive mentoring from the AD from a sister facility, however these processes were not completed prior to the AD assuming the positions role and responsibilities in the facility. Review of the facility policy Activities Director Qualifications dated 01/01/24 revealed the Policy statement This facility ' s activities program is directed by a qualified professional. The Policy Explanation and Compliance Guidelines included the following entries: 1. The Activity Director, at a minimum, shall meet the following qualifications: a. Licensed or registered, if applicable, by the State in which practicing; and b. One or more of the following: i. Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; ii. Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; iii. Is a qualified occupational therapist or occupational therapy assistant; or iv. Has completed a training course approved by the State. 2. Qualifications shall be verified prior to hire as Activity Director.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49699 Based on observation, interview and record review the facility failed to ensure one resident (R441) of four residents reviewed were repositioned timely and appropriately resulting in an acquired pressure ulcers (damage to skin and underlying tissue over bony areas). Findings include: On 4/23/24 at 9:26 AM, R441 was observed lying on their back. R441 heels were on bed surface with a small foam boot around her right ankle and another small foam boot lying under the left calf. A review of the facility's electronic medical record (EMR) revealed that R441 was admitted on [DATE]. Diagnoses include Atrial Fibrillation, Myocardial Infarction (heart attack), Chronic Obstructive Pulmonary Disease, Anxiety Disorder, Chronic Kidney Disease, Morbid Obesity (severe), Dysphagia, Low Back Pain, and Dementia. R441's Minimum Data Set (MDS) revealed severe cognitive impairment. On 4/23/24 at 11:37 AM and 2:30 PM, R441 was observed lying on their back with heels on surface of bed. No heel protection in place On 4/24/24 at 9:04 AM, R441 was observed lying mostly on their back, slightly turned to the side with a flat pillow partially under left upper body. R441's small foam boots were around lower calf with heels on bed surface. On 4/25/24 at 10:10 AM and 2:15 PM, R441 was observed lying on the right side with a wedge holding R441 off their buttocks. There was no heel protection in place. On 4/25/24 at 10:05 AM, Nurse C was queried regarding R441. Nurse C, when queried about repositioning schedules, documentation of repositioning, or documentation of refusal to reposition could be found, they replied that they did not know where refusal to reposition was documented. Nurse C was asked how they know if resident needs assisted repositioning and if it is being done. Nurse C stated, I would look at the resident as I am passing meds or doing treatments to see if residents are in different positions. On 4/25/24 at 11:19 AM, an interview with Certified Nursing Assistant (CNA), A revealed that she is not a regular on the floor but works on this unit often. CNA A was queried as to how she knows when a resident should be repositioned. CNA A indicated a schedule attached to their ID badge that has a picture for the position assigned when residents are repositioned every 2 hours. On 4/25/24, at 1:04 PM, CNA B was queried regarding where they document refusal to reposition. CNA B stated they were not sure. Then offered to demonstrate the Kiosk documentation where charting is done. They related they tell the nurse when a resident refuses to reposition after a few times. Review of the Electronic Medical Record (EMR) Nurse Practitioner O on 4/3/24, revealed .a stage three pressure ulcer on coccyx today. The note further revealed an order for z-guard (protective cream) and every two hour turns with a follow up for wound care on Friday. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR, dated 4/5/24, revealed Wound Care Practitioner H (WCP) evaluated R441's sacral wound as follows: revealed a referral for developed ulcer on the sacrum (buttock area). R441 wanted to be left alone. R441 is on a foam pressure reducing mattress. WCP G documented the following findings: Sacral is a Stage three Pressure Injury Pressure Ulcer (full thickness tissue loss) and has received a status of Not Healed. Initial wound encounter measurements are two-point-five centimeters (cm) length by two centimeters (cm) in width by zero-point-three centimeters (cm) in depth, with an area of five square cubic centimeters. There is a small amount of sero-sanguineous drainage noted. The patient reports a wound pain of level five of a possible 10 on a scale of one to ten, with one being no pain, to ten being excruciating pain. The wound margin is well defined. Wound bed is 26-50% granulation (healthy tissue), 26-50% slough (non-healthy). The periwound (area surrounding the open area of the wound) skin texture, moisture and color is normal. Periwound skin does not exhibit signs and symptoms of infection. Review of the EMR, dated 4/6/24, the weekly Skin Sweep identified a discoloration that was on R441's forehead from a previous fall. The sacral wound was not identified. On 4/25/24, a review of the EMR, dated 4/8/24, a Braden Scale Score (risk prediction for wound development covering six areas, with scores of one to four) of 16 indicating that the resident was at Mild Risk for development of a wound. On 4/2/24, a review of the EMR for R441 revealed a Treatment Administration Record (TAR) indicated the first wound treatment order occurred on 4/11/24. Review of R441's EMR revealed that there was not a care plan for pressure wound care or prevention and there is no care plan addressing floating the heels. Review of R441's Kardex (a document used by certified nursing assistants to guide the care required) required documentation for floating heels as care planned. The document has three areas for documentation daily. Between 4/12/24 and 4/25/24, there are three incidents of documentation that indicated that the heels were not floated. Those incidents are 4/13/24 at 10:30 PM, 4/14/24 at 2:19 AM and 4/22/24 at 6:09 PM. On 4/25/24 at 1:35 PM, an interview with Director of Nursing (DON) was conducted, and she was inquired about her expectation for repositioning changes. She explained that repositioning should occur regularly based on the residents' needs. When queried regarding documentation of repositioning, the DON revealed that the repositioning schedule indicated by CNA A is not a (facility) practice. When queried further about R441, DON indicated that R441 could stand so did not see the need for this type of care plan. Further query as to where refusals for repositioning are documented, she did not respond. A review of the facility policy titled Skin & Pressure Injury Risk Assessment and Prevention revealed the following, Residents determined as at risk for developing pressure injuries will have the interventions documented in plan of care based on specific factors identified in the risk assessment . Evidence based interventions for prevention will be implemented for residents who are assessed at risk and/or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: Redistribute pressure, provide appropriate, pressure-redistributing, support surface. Evidence-based treatment in accordance with standards of practice will be provided for all residents who have a pressure injury present.

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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 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** 49699 Based on observation, interview, and record review, the facility failed to provide and document weight loss interventions for one resident (R5) of two residents reviewed for nutrition resulting in weight loss. Findings include: On 4/23/24 at 10:44 AM, R5 was observed lying in bed in a fetal position. R5's appearance was very thin and emaciated (muscle and fat loss) with skeletal appearance and visible bones beneath skin surface, sunken cheeks, and very thin arms and legs. R5's water pitcher was observed with thickened liquid and a straw on his overbed table. A review of the facilities electronic medical record (EMR) revealed that R5 was admitted on [DATE]. R5's diagnoses included Metabolic Encephalopathy, Adult Failure to Thrive, Urinary Tract Infection, Diabetes Mellitus, Intracerebral Hemorrhage, Protein-Calorie Malnutrition, Hypertension, and Dysphagia. A review of the Minimum Data Set (MDS) revealed a severe cognitive impairment. 4/24/24 at 12:16 PM, R5 was observed in bed, with head of bed elevated to 45 degrees while eating pureed lunch foods, no heel boots on, heels on bed surface. Thick opaque liquid in cup with straw. No supplements on tray. On 4/24/24 at 4:53 an interview with the Registered Dietician E (RD) revealed they were aware of the significant weight loss of 17.97% over a 6-month period and confirmed R5 is receiving hospice services. RD E also revealed that R5 was provided supplements in the past with Med Pass (a supplement to be given while medications are passed) of 120 milliliters (ml) given with medication, and Mighty Shakes 120 milliliters (ml) per meal. RD E revealed resident often refused these supplements and they went to waste. They further stated that when R5 changed they're status to hospice, they no longer received supplements. On 4/24/24 at 5:10 PM, the EMR revealed that R5 had an order on September 8, 2023 for Med Pass 120 ml (milliters) and Mighty Shakes, 120 ml with meals. Supplement administration continued thru October 7, 2023, when resident was hospitalized . Further review revealed no incident of refusal to consume the med pass supplement or Mighty Shakes. The med pass and Mighty Shake order was not resumed on R5's return from the hospital. The EMR revealed an order for Hospice upon his return from the hospital. A review of the EMR revealed R5 was discharged to the hospital on 10/8/23. The weight on 10/6/23 was 118 pounds. R5 returned to the facility on [DATE]. The next documented weight on 1/8/24 was 110 pounds. A record review revealed a steady decline in R5's weight. -5/7/23 - 136.4 pounds. -6/12/23 - 136.6 pounds. -7/18/23 - 135 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/3/23 - 134.8 pounds -9/7/23 - 129 pounds Review of nutritional summary on 1/23/24 revealed that R5 was on a regular puree diet with mild/nectar thick liquids. Care planning was to document daily food acceptance of provided altered texture meals. The summary revealed that R5 was consuming 75% or more of most meals. Caloric needs were revealed to be 1875-2250kcal per day with 75-90 grams of protein. The summary further reveals that R5 has history of non-compliance with his diet order and understands the risks. RD E further revealed that down trending weight loss may be anticipated related to medical diagnosis. A nutritional summary dated 4/24 revealed R5 was consuming about 50% or more of his lunch on that date. The nutritional summary further revealed that R5's appetite fluctuated so that he was consuming 25-100% of his meal. On 4/25/24 an interview with the Director of Nursing (DON) revealed that all residents were to be assessed and receive interventions appropriate to their needs whether or not they are utilizing hospice services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on observation, interview, and record review, the facility failed to administer a tube feeding in accordance with the physician's orders for one resident (R81) of one resident reviewed for tube feeding, resulting in the potential for weight loss and dehydration. Findings include: In an observation on 4/23/24 at 9:13 a.m., R81 had a tube feeding pump in room with no feeding running. Review of an Admission Record revealed, R81 originally admitted to the facility on [DATE], and readmitted on [DATE] with pertinent diagnosis which included severe protein-calorie malnutrition and dysphagia (difficulty swallowing). Review of a Minimum Data Set (MDS) assessment dated of 1/9/24 revealed R81 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 00 out of 15 (indicating severely impaired cognition) and required a feeding tube. Review of Physician orders revealed R81 had an order for Jevity 1.5 (tube feeding formula) one time a day to be up at 5pm until dose complete. Review of a Medication Administration Record (MAR) for March through April 2024 revealed Jevity 1.5 not documented as given on 3/1, 3/3, 3/5, 3/17, 3/21, 4/10, 4/11, and 4/19/24. Residual checks not documented as being checked on 3/1, 3/2, 3/8, 3/12, 3/15-3/17, 3/21, 3/24, and 3/25/24. In an interview on 4/24/24 at 12:20 p.m., Licensed Practical Nurse (LPN) M was asked how often is R81's residual checked. LPN M replied residual should be checked before tube feedings and medication administration. LPN M then reported there should be an order to check residual. In an interview on 4/25/24 at 10:26 a.m. the Director of Nursing (DON) was asked about documentation of R81's tube feeding administration. The DON stated, If it's not documented it's not done. The DON then reported the nurse should document after administering the tube feeding. The DON reported the Physician said checking residual is not necessary for residents with tube feedings. The DON then reported in the event a resident is having a problem with the PEG (tube inserted in stomach for nutrition) tube, documenting residuals would be appropriate. In an interview on 4/25/24 at 2:00 p.m., Nurse Practitioner (NP) O reported residents with chronic tube feedings do not require consistent residual checks. NP O then reported residual checks are only required when there is an identified concern with the PEG tube or feeding. Review of a Care and Treatment of Feeding Tubes policy revised 6/23 documented the following: It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. 1. Feeding tubes will be utilized according to physicians orders . 4. Tube placement will be verified before beginning a feeding and before administering medications .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39958 Based on observation, interview, and record review, the facility failed to obtain Physicians orders for dialysis treatment and to monitor the dialysis site (catheter) for one (R73) of one resident reviewed for dialysis services, resulting in the potential for undetected complications associated with receiving dialysis, including bleeding, infection, and site failure. Findings include: In an interview on 4/24/24 at 9:14 a.m., Licensed Practical Nurse (LPN) M reported R73 has dialysis on Monday, Wednesday, and Fridays. Review of an Admission Record revealed, R73 originally admitted to the facility on [DATE], and readmitted on [DATE] with pertinent diagnosis which included End Stage Renal Disease and Type 2 Diabetes. Review of a Minimum Data Set (MDS) assessment dated of 3/1/24 revealed R73 had no cognitive impairment with a Brief interview for Mental Status (BIMS) score of 15 out of 15 and required dialysis. Review of Physician orders revealed R73 did not have an order for dialysis or to monitor the dialysis site. In an interview on 4/24/24 at 11:49 a.m., LPN M reported R73 should have an order for dialysis and it usually pops up in the MAR (Medication Administrtion Record). LPN M and LPN N confirmed there was no order for R73 to receive dialysis. In an interview on 4/24/24 at 11:53 a.m., LPN N reported there should be an order to monitor R73's dialysis site (catheter or fistula). In an interview on 4/24/24 at 11:56 a.m., LPN M reported there is a discontinued order for R73 to receive dialysis on 4/19/24 that was never reactivated when R73 readmitted to the facility. Reviewed of dialysis communication sheets for March and April 2024 revealed R73'dialysis site not assessed or documentded on the form. In an observation on 4/24/24 at 1:34 p.m., R73 was observed with a port in right upper chest. In an interview on 4/25/24 at 10:30 a.m., the Director of Nursing (DON) reported should have an order to receive dialysis. The DON then reported R73's order for dialysis was active before being discharged . and orders were not reactivated. Review of a Dialysis Special Needs Care policy revised 6/23 documented the following: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders . to meet the special medical, nursing, mental, and psychosocial needs of residents receiving dialysis .

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Mission Point Nsg & Phy Rehab Ctr of Clinton Twp	17001 17 Mile Rd Clinton Township, MI 48038

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40384 Based on observation, interview, and record review, the facility failed to monitor the temperatures of one of one medication refrigerator that stored drugs and biologicals. Findings include: On 4/25/24 at 9:50 AM, the Station One medication refrigerator was viewed with Licensed Practical Nurse (LPN F). The temperature log for April 2024 had no documentation for the AM shift, and three days missing on the PM shift: 4/23, 4/24, and 4/25. The temperature log for March 2024 was missing multiple days without refrigerator temperature documentation that included no temperatures taken on the AM shift, and no documentation on 3/29, 3/30, and 3/31. The temperature log for February was missing the following temperature documentation for the AM shift: 2/1, 2/2, 2/4, 2/6, 2/8, 2/16, and 2/21-2/29, and no PM temperature documentation for 2/1, 2/2, 2/3, 2/5, 2/9, 2/16, 2/19 and 2/24. The temperature log for January was missing the following temperatures during the AM shift: 1/3, 1/4, 1/5, 1/8, 1/9, 1/11, 1/13, 1/15-1/17, 1/22, 1/23, 1/25. 1/27, 1/31, and no PM temperature documentation on: 1/13, 1/27, and 1/29. Licensed Practical Nurse (LPN) F was asked about the missing documentation, and acknowledged the missing dates, and stated, This is embarrassing. On 4/25/24 at 2:05 PM, the Director of Nursing (DON) was informed of the surveyor's observation in the Station One medication room, and explained that the expectation is that the temperature logs be completed on both the AM and PM shifts. The facility's Storage and Stability of Selected Medications was reviewed and did not address the monitoring of medication refrigerator temperatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235405	A. Building B. Wing	04/25/2024

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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. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 4/23/24 between 8:45 AM-9:30 AM, during an initial tour of the kitchen, the following items were observed: There was a personal cell phone on the food preparation counter. On 4/23/24 at 11:15 AM, Dietary Manager (DM) P confirmed the cell phone should not have been left on the food preparation counter. According to the 2017 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination, FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. The flour bin located inside the dry storage room was observed with the scoop stored inside the bin, with the handle resting in the flour. On 4/23/24 at 11:17 AM, DM P confirmed the scoop should not have been stored inside the flour. According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: .(B) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon; There was a box of orange juice concentrate stored on the floor, being utilized to prop open the dry storage room door. According to the 2017 FDA Food Code section 3-305.11 Food Storage, 1. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: 1. (1) In a clean, dry location; 2. (2) Where it is not exposed to splash, dust, or other contamination; and 3. (3) At least 15 cm (6 inches) above the floor. The top surface of the Southbend steamer was observed with a buildup of grease and crumbs. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. There was a wet wiping cloth lying on the food preparation counter. The rag was not stored inside sanitizer bucket, and there were no prepared sanitizer buckets anywhere in the kitchen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235405	A. Building B. Wing	04/25/2024

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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	According to the 2017 FDA Food Code, Section 3-304.14 Wiping Cloths, Use Limitation, .(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 4-501.114; There was dried food splatter on the inside surface of the microwave. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, .(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The shelf at the front of the steam table was warped, with large cracks and exposed, porous particle board. The surface of the shelf was no longer smooth and easily cleanable. When queried on 4/23/24 at 11:25 AM, DM P stated a new shelf would be ordered. According to the 2017 FDA Food Code section 4-101.19 Nonfood-Contact Surfaces, NonFOOD-CONTACT SURFACES of EQUIPMENT that are exposed to splash, spillage, or other FOOD soiling or that require frequent cleaning shall be constructed of a CORROSION-RESISTANT, nonabsorbent, and SMOOTH material. Dietary staff members Q and R were observed using the dish machine. When queried about how to check the dish machine for adequate sanitization, Dietary Staff Q stated she was new and did not know. Dietary Staff R stated she would check the dial for the wash and rinse temperature. When queried about checking the chemical sanitizer level for the low temperature, chemical sanitizing dish machine, Staff R stated she did not know how to do that. The log for documenting the sanitization of the dish machine was blank on 4/22 dinner and 4/23 breakfast. According to the 2017 FDA Food Code section 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration, Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device. Pf