STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235408	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Healthcare Center	31830 Ryan Rd Warren, MI 48092

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 Based on observation, interview, and record review, the facility failed to ensure paper towel dispensers were accessible for one (R9) resident and two anonymous group residents of five residents reviewed for accommodations. Findings include: Review of the facility record for R9 revealed an admitted [DATE] with diagnoses that included Osteoarthritis, Pain in the Right Shoulder, Pain in the Left elbow, and Left Tibia/Fibula Fractures. On 05/07/24 at 7:44 AM, during initial resident screening R9 reported the paper towel dispensers in their bathroom and in the first floor dining room were too high and they couldn't reach them. R9 reported that they are not able to stand independently and they have limited shoulder range of motion. On 05/08/24 at 2:02 PM during Resident Council, two anonymous group members reported they were not able to reach the paper towel dispenser in their bathrooms or in the first floor dining room. These group members reported they had communicated this concern to the facility Maintenance Director and the facility Administrator (NHA) multiple times with no response or resolution. On 05/09/24 at 10:17 AM, R9 reported they expressed their concern about not being able to reach the paper towel dispensers to management and they were told we'll look into it. R9 stated they had brought the issue up in previous Resident Council meetings and they were told by the Resident Council President that they had also mentioned it to management. R9 was observed demonstrating the ability to wheel their chair into the bathroom and reach for the paper towel dispenser without being able to reach or grab the paper towel. R9 reported they usually end up wiping their hands on their clothing unless staff happen to be nearby to assist. Review of the facility Resident Council meeting minutes for April 2024 indicated that the paper towel dispenser issue was discussed and documented as a maintenance department-related concern. On 05/09/24 at 4:11 PM, the facility Resident Council President reported they had brought up the issue of the paper towel dispenser being too high on the wall when there was a different Maintenance Director saying, it's been months since initially reported. On 05/09/24 at 1:39 PM, the NHA reported the expectation is the paper towel dispensers should be accessible to all resident's. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Federal & State - Guest/Resident Rights & Facility Responsibilities dated 04/19/22 revealed the entry 3. Reasonable Accommodation. The right to reside and receive services in the facility with reasonable accommodation of guest/resident needs and preferences except when to do so would endanger the health or safety of the guest/resident or other guests/residents. The Safe, clean, comfortable & homelike environment portion of the policy included the entry i. This includes ensuring that the guest/resident can receive care and services safely and that the physical layout of the facility maximizes guest/resident independence and does not pose a safety risk.

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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** 32220 Based on observation, interview, and record review the facility failed to ensure care planned interventions were implemented for two residents (R74, R102) of three reviewed for care and repositioning needs resulting in and the potential for unmet care needs. Findings include: R74 On 05/07/24 at 8:55 AM R74 was observed to be supine (flat on the back and buttocks) in bed with the head of the bed up around 30-45 degrees. R74 was asked about their care and reported they had a wound to their buttocks which felt sore and had consistent pain from the area along with their feet. The pain level was reported to be a ten out of ten sometimes and an eight at the time of the interview. R74 was asked about positioning off the wound area and reported they had a wedge in their old room but it did not come with them and needed a new one. An observation of the resident area revealed no wedge or pillow or other device to be used to off load pressure. R74 reported they needed assistance to turn side to side. On 05/07/24 at 4:24 PM, R74 was observed with their eyes closed and appeared to be asleep supine in bed. The head of bed was up around 30-45 degrees and the resident leaned slightly to the left. On 05/08/24 at 8:01 AM, R74 was observed to be supine in bed with the head of the bed elevated around 20-30 degrees. R74's torso leaned slightly to their left and R74 had their eyes closed and appeared to be asleep. A wedge nor other device to redistribute weight was observed. On 05/08/24 at 10:10 AM, R74 was observed to be supine in bed without the benefit of a wedge or other device. A nurse used the control to sit R74 higher up in bed and R74 made a noise (like oh). R74 indicated they were in pain and the nurse reported they would call the doctor. On 05/08/24 at 11:46 AM, R74 was supine in bed asleep with the head of bed up 30-45 degrees without an observed wedge or device. The torso and head leaned slightly toward their left. On 05/08/24 at 5:00 PM, R74 was observed to be supine in bed, the head of the bed around 30-45 degrees. A wedge, pillow or other device was not observed at the side of the resident nor in the resident area. On 05/09/24 at 7:57 AM, R74 appeared to be asleep supine in bed, no wedge or device visible, heel booties on and the head of the bed elevated 30-45 degrees with their torso and head leaned slightly over to the their left. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/24 08:44 AM, R74 buttocks wounds were observed with the wound care nurse and Certified Nursing Assistant (CNA) G. R74 was supine as before without any observed devices to offload. R74 did not appear to assist when turned onto their side. The wound areas covered the medial aspects of both buttocks along the gluteal cleft and appeared in width about the size of a softball. The surface appeared slightly raw and red with some darker maroon and purple areas as with a deep tissue injury. As the nurse touched the wound area to cleanse it from the barrier paste R74 reacted with (ooh like noise) and reported pain. R74 was returned to their backside (supine) without any devices in place. On 05/09/24 at 9:10 AM, CNA G was asked about the care of R74 and reported R74 did not like the wedge or the pillow and had found it on the floor at times. CNA G also reported R74 had told them they thought having a dressing in place would help the pain. On 05/09/24 at 9:14 AM, R74 reported they had a wedge in their old room, the wedge is comfortable, and liked it especially at night. R74 was observed to be supine in bed with the head of the bed elevated around 30-45 degrees. A review of the record for R74 revealed R74 was admitted into the facility on [DATE]. Diagnoses included Stroke, Diabetes and Urine Retention. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and the need for substantial to maximal assistance to roll left to right, personal hygiene, upper and lower body dressing, sitting to lying, lying to sitting, sitting to standing and transfer. Review of the .has actual impairment to skin integrity . care plan (initiated 08/22/23) revealed, .Apply pressure reducing/relieving mattress, pillows . (initiated 08/22/23).Positional wedge for effective positioning to relieve pressure to bony prominences as tolerated . (initiated 04/18/24). The .at risk for impaired skin integrity . care plan revealed: .Cue to reposition self as needed (initiated 08/22/23). Turn/reposition resident every two hours and as needed . (initiated 08/22/23). The .at risk for pain . care plan (revised 01/02/24) revealed, .Anticipate resident's need for pain relief . (initiated 08/22/23).Encourage/provide non-pharmacological interventions to prevent/manage pain as needed such as positioning devices . (initiated 08/22/23). A review of the .at risk for catheter related trauma . care plan (revised 02/20/24) revealed, .Ensure catheter tubing is secured . (initiated 02/20/24). On 05/09/24 at 12:18 PM, the Director of Nursing (DON) reported they had challenges with the care of pressure sores in the past but felt the facility had been doing a good job with the care of wounds. The DON also noted R74 had a history of refusing the wedge or other assistance. The DON reported R74 was on an LTC 105 FLO mattress which was rated for stage three and four pressure sores and did not require and the wedge was contraindicated. The manufactures' specifications were requested and revealed, .wound clinicians have trusted (name) for the most severe wounds (Stage I - IV). Both Pressure & Shear Relief Therapy (name) consistently delivers interface pressures below 32 mmHg (millimeters of mercury), while the six degrees of cell movement combat shear forces associated with repositioning . The information provided did not prohibit the use of devices for repositioning and the included pictures documented increased pressure (two millimeters of mercury) and surface contact area (373 square centimeters) for a supine person when the bed was elevated from zero degrees to 30 degrees. R102 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/24 at 8:29 AM, R102 was observed to be seated supine in a recliner in the dining room. R102 was dressed, had their head back, face up toward ceiling, and eyes closed. The eyes opened to a call of their name. A pad was visible under the resident and extended to the head and foot and over the arms of the chair. This was reported as a pressure relieving device. On 05/07/24 at 11:42 AM, R102 was seated supine in a recliner elevated 60-90 degrees during an activity in the dining room. On 05/07/24 at 1:53 PM, R102 was seated supine in recliner in dining room head back eyes closed. The recliner elevated 45-60 degrees. On 05/07/24 04:22 PM, R102 was observed to be in bed supine, torso toward left slightly, head of bed, 20-30 degrees and appeared asleep. On 05/08/24 at 8:05 AM, R102 was supine in the recliner at nurse station elevated around 20-30 degrees, head back with face toward ceiling. Staff entered area, said hello, R102 returned a greeting and returned their head back to pillow again with their face toward the ceiling. On 05/08/24 at 8:47 AM, R102 was supine in the recliner in the dining room, elevated 60-90 degrees with head back and face toward the ceiling. On 05/08/24 at 9:45 AM, R102 was seated supine in the recliner elevated 60-90 degrees and leaned forward while eating breakfast. On 05/08/24 at 11:47 AM, R102 was observed seated supine in the recliner elevated 60-90 degrees during an activity in the dining room. On 05/08/24 at 1:40 PM, R102 was observed in the same spot at the table as before, seated supine in the recliner elevated 60-90 degrees. On 05/08/24 at 2:00 PM, R102 was observed in the day room area during a puzzle activity. R102 was seated supine in the recliner elevated 60-90 degrees. R102 was observed to press their elbows and forearms into the arms of the chair in attempts to push themselves up from the seat of the recliner. Their legs were off the elevated footrest. R102 reported they were uncomfortable upon query as to why they were moving. On 05/09/24 at 7:40 AM, R102 was observed at the nurse's station, supine in the recliner elevated around 20-30 degrees and had their eyes closed. On 5/09/24 at 1:38 PM, R102 was seated supine in the recliner elevated 60-90 degrees, eating lunch in the dining room. At 2:36 PM R102 was as before in the same spot. On 05/09/24 at 3:28 PM, CNA G was asked about the positioning of R102 and reported the pad under R102 in pressure relieving and R102 had been returned to bed three to four times for incontinence care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the record for R102 revealed R102 was admitted into the facility on [DATE] and readmitted on [DATE]. Diagnoses included Pressure Ulcer of the Sacral Region, Stroke and Dementia. The MDS dated [DATE] documented impaired cognition and the need for substantial to maximal assistance to roll left to right, personal hygiene, upper body dressing, sitting to lying, lying to sitting, sitting to standing and transfer. Review of the .at risk for impaired skin integrity . care plan revealed: .Cue to reposition self as needed (initiated 10/25/23). Turn/reposition resident every two hours and as needed . (initiated 10/25/23). The .has actual impairment to skin integrity . care plan (revised 08/17/23) revealed, .Positional wedge for effective positioning to relieve pressure to bony prominences as tolerated . (initiated 06/08/23). A wedge or similar device was not observed to be used while R102 was in the recliner and R102 did not appear to be turned left or right while up in the recliner. A wound note dated 04/26/24 documented a sacral pressure ulcer five cm long by two .five cm wide by 0.5 cm deep. On 05/09/24 11:43 AM and 4:17 PM, care concerns were reviewed with the DON. The DON reported R102 had refused the wedge and pillow in the past and when staff had attempted to place it that day. The DON acknowledged the wedge was still in the care plan and was asked about care planned interventions and reported interventions should be followed until they are not in effect anymore and residents up in the recliners should be repositioned every two hours and as needed. Review of the facility policy titled, Care Planning revised 06/24/21 revealed, Every resident in the facility will have a person centered plan of care developed and implemented that is consistent with the resident's rights, based on the comprehensive assessment . A review of the facility policy titled, Skin Management revised 07/14/21 revealed, .It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on observation, interview, and record review, the facility failed to ensure an incontinence pad and gown were changed during incontinence care and clothing was available for one resident (R119) of one reviewed for care. Findings include: On 05/07/24 at 8:05 AM, R119 was asked about their care. R119 was observed to be dressed in a hospital style gown and brief which hung loosely on them. The gown was off the shoulder. R119 was asked about wearing a gown and if they wanted to wear clothes and said they would prefer to wear clothes but did not have any. The drawers and closet were observed and a single pair of pants were seen to be folded over a pants hanger in the closet. On 05/07/24 at 11:24 AM, Certified Nursing Assistant (CNA) I was observed to exit the room of R119. On 05/07/24 at 11:25 AM, R119 was observed to be supine in bed wearing a brief and a gown. R119 was interviewed about their care and reported the pad and gown were wet. A gloved hand was used to test the bed and gown which were found to be wet. The call light was activated by R119 and at 11:35 CNA I returned and asked R119 if they were wet to which R119 confirmed they were wet and CNA I went out and returned with a brief and pad. On 05/07/24 at 4:02 PM, R119 was observed dressed in a gown and brief. The feet were bare. On 05/08/24 at 8:45 AM, R119 was observed to be in bed, supine in a gown, a brief was observed on the floor. On 05/08/24 at 9:47 AM, R119 was observed to be supine in bed and had on the pants that hung in the closet the day before. R119 did not have a shirt on. On 05/08/24 at 11:53 AM, a laundry staff member was asked about clothes for R119 and was not sure what R119 had but had delivered clothes to the room the day before. R119 was asked if they would like more clothes and said of course. A white printed t-shirt was noted on night stand with a gray pair of sweat pants. R119 was dressed in the other pair of pants and no shirt. The pants were observed to have a split seam on the left pant leg. On 05/08/24 at 2:09 PM, Licensed practical nurse (LPN) K was asked about the protocol for residents without clothes as R119 had been a resident at the facility since December 2023. LPN K reported they had donated items in the laundry but R119 particular on what they want to do and may or may not wish to have clothes when asked. LPN K went in and asked R119 about clothes and at first reported they did not care, then prompted another time R119 asked for clothes and discussed sizes and style. LPN K then reported they would check the laundry for some clothes for R119. On 05/08/24 at 2:55 PM, Social Worker L reported R119 had not asked for clothes until 04/26/24 and had emailed the guardian for approval to purchase some clothes but had not heard back. A review of the admission inventory sheet documented one pair of pants and one shirt and a pair of shoes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/24 at 7:54 AM, R119 was observed to be in bed, laying on their left side, asleep, shoes at side of bed, with pants and a t-shirt on. On 05/09/24 at 4:17 PM, the Director of Nursing (DON) was asked about the identified care concern and reported R119 is able to use the urinal independently and the CNA may not have checked the pad and gown. A review of the record for R119 revealed R119 was admitted into the facility on [DATE]. Diagnoses included Dementia and Heart Failure. A review of the active care plans documented R119, .has psychosocial well-being problem related to lack of motivation/does not ask for assistance .is incontinent of bladder and or bowel .has a functional ability deficit and require assistance with self care .Encourage to choose own clothing daily .Encourage to assist in self care as much as possible, provide positive reinforcement for all activities attempted . A review of the Minimum Data Set assessment dated [DATE] documented impaired cognition with a 7/15 Brief Interview for Mental Status score and the need for partial/moderate assistance for upper body dressing and substantial/maximal assistance for lower body dressing and putting on/taking off footwear. A review of the facilities Standard of CNA/STNA Practice revised 08/15/23 revealed, .The CNA/STNA makes routine rounds to check each assigned resident's condition and ensures their needs are met . A review of the facility policy titled, Guest/Resident Rights & Facility Responsibilities revised 04/08/22 revealed, .Guest/Residents Rights. The guest/resident has a right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. 1. Dignity, Respect & Quality of Life. A facility must treat each guest/resident with respect and dignity and care for each guest/resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each guest's/resident's individuality. The facility must protect and promote the rights of the guest/resident .Planning and Implementing Care. The guest/resident has the right to be informed of, and participate in, his or her treatment, including: 1. Information Regarding Health Status. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. 2. Participation in Plan of Care. The right to participate in the development and implementation of his or her person-centered plan of care .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on observation, interview, and record review, the facility failed to store medication in a safe and secure manner for one resident (R439), failed to discard expired medication in one of two medication storage rooms, and failed to label medications in three of five medication treatment carts reviewed for medication storage and labeling. Findings include: R439 On [DATE] at 8:00 AM, during an initial tour of the facility an observation was made of four pills in a small plastic cup being on a table top located next to R439's bed. R439 was interviewed regarding the medication on the table top and asked if they self administered their medications. R439 stated, They give me my pills. On [DATE] at 1:34 PM, a record review was completed of R439's electronic medical record (EMR) and it revealed no assessment documentation which indicated that R439 was able to self administer their medication. Further review of R439's EMR revealed that R439 was admitted to the facility on [DATE] with diagnoses that included Multiple sclerosis (Autoimmune disease) and Hypertension. R439's most recent minimum data set assessment (MDS) dated [DATE] revealed that R439 had an intact cognition. On [DATE] at 12:15 PM, the Director of Nursing (DON) was interviewed about resident's self administering of their medications and medications being left at a resident's bedside unmonitored. The DON indicated that a resident's medication should only be unmonitored and left at the resident's bedside if the resident has been assessed and deemed to be appropriate to self administer their medications. 32220 On [DATE] at 5:34 PM, an observation of the second floor A medication cart with Licensed Practical Nurse (LPN) A revealed and open and undated, Basalgar insulin pen, and open and undated Glargine insulin pen and an open and undated Levemir insulin pen. A vial of glucose test strips also not dated when opened and or with an expiration date. On [DATE] at 6:05 PM, an observation of the Rehab medication cart A with Registered Nurse (RN) B revealed a Latanoprost .005% eye dropper vial were open and undated and without a resident identifier on the vial. On [DATE] at 9:08 AM, an observation of the one north A medication cart with LPN D revealed, a Humalog insulin vial was not labeled with a resident identifier, a Breo inhaler was not labeled with a resident identifier on the inhaler, and a Trellegy inhaler was not labeled with the date opened or the expiration date on the inhaler. 49699 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:55 AM, accompanied by Licensed Practical Nurse (LPN) F six bottles of Primidone Suspension (seizure medication) were observed with expired use by dates of [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Nurse F verified the use by date and indicated they had not administered that medication today. A review of the facility policy titled, 5.3 Storage and Expiration Dating of Medications, Biologicals was reviewed, with last revision date of [DATE]. In part it revealed. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on interview and record review, the facility failed to ensure that one resident (R125) was offered a bedtime snack of eight residents reviewed for snacks, resulting in nighttime hunger. Findings include: On 5/7/24 at 7:56 AM, during an initial tour of the facility R125 was interviewed and asked about their level of satisfaction with the food and snacks provided to them at the facility. R125 stated, I just found out I could get a snack a couple weeks ago. I get hungry after dinner. On 5/8/24 at 10:30 AM, R125 was further interviewed about bedtime snacks and indicated they had never been offered a bedtime snack. R125 stated, I'm not sure what's available. On 5/9/24 at 10:29 AM, a review of R125's electronic medical record (EMR) and a thirty day review of bedtime snacks offered to R125 revealed documentation which indicated that R125 was not offered a bedtime snack on the following dates: 4/12/24, 4/13/24, 4/14/24, 4/18/24, 4/19/24, 4/27/24, 4/28/24, 5/4/24, 5/7/24, and 5/8/24. On 5/9/24 at 10:35 AM, a further review of R125's EMR revealed that R125 was admitted to the facility on [DATE] with diagnoses that included Metabolic encephalopathy (Brain disorder) and Generalized anxiety disorder. R125's most recent minimum data set assessment dated [DATE] revealed that R125 had a moderately impaired cognition. On 5/9/24 at 1:13 PM, Activity Director (AD) J was interviewed regarding the process for offering and documenting the offering of bedtime snacks to residents. AD J provided the surveyor with a paper with [corn chip product] listed by R125's name and the date 5/7/24. AD J indicated the evening activity aides offer and pass out bedtime snacks to residents and document the information on paper like the one that was provided to the surveyor. AD J indicated the Certified Nursing Assistants (CNAs) are supposed to put the snack documentation in the EMR. On 5/9/24 at 1:35 PM, the Administrator (NHA) was interviewed regarding their expectations for offering and providing bedtime snacks to residents. The NHA indicated the expectation was residents who do not have [dietary/medical restrictions] should have a snack offered nightly. On 5/9/24 at 2:00 PM, a facility policy titled, Snacks Last Revised: 11/8/2021 was reviewed and stated the following, Policy: It is the policy of this facility to provide snacks as ordered and Hour of Sleep (HS) snacks will be offered to all guests/residents. Procedure: 5. Bedtime snacks will be offered to guests/residents at HS; the Nursing department will document the acceptance or refusal on the Food Acceptance/Snacks form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235408	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Healthcare Center	31830 Ryan Rd Warren, MI 48092

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 main floor kitchenette, and in the rehab and second floor pantry. This deficient practice had the potential to affect all residents in the facility that consume food. Findings include: On 5/7/24 between 8:30 AM-9:15 AM, during an initial dietary tour with Dietary Manager (DM) M, the following items were observed: Rehab Pantry: In the resident refrigerator located in the Rehab Unit pantry, there was an undated container of spaghetti, a container of macaroni salad with a use-by date of 5/3, an undated bag of sliced ham, and 3 undated slices of pie. When queried, DM M stated nursing staff is responsible for ensuring resident food items are dated. In addition in the Rehab pantry, there were ants observed on the floor surrounding the floor drain next to the ice machine, with piles of ant dirt observed around the floor drain. DM M stated she would let maintenance know about the ant problem. Main 1st floor dining room: In the kitchenette located in the first floor dining room, the interior top surface of the microwave was observed to be heavily soiled with dried on food debris. DM M confirmed the soiled microwave. The flooring in the kitchenette was heavily soiled with sticky spills, food debris and trash. DM M stated housekeeping was responsible for cleaning the floors. In the resident refrigerator located in the kitchenette, there was an undated container of cut strawberries and an undated box of pizza. There was no refrigerator temperature log for the current month (May), and the April temperature log located on the front of the refrigerator was observed with incomplete entries for the last half of the month. DM M confirmed the refrigerator temperature should be logged daily. 2nd floor pantry: In the resident refrigerator, there were 4 undated containers of unidentified food items, some of which were emitting a pungent, rotten odor. In addition, the interior of the refrigerator was soiled with food debris and sticky spills. Review of the facility's policy Food From Outside Sources revised 11/12/21 noted: 5. All food brought in . must be placed in a sealed container and labeled for the content, the guest's/resident's name and date the food was received, and an expiration date of 3 days after food was brought in.