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	06/11/2025

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to consistantly implement an effective measure (seperation) to prevent further abuse during an abuse investigation for one resident (R324) out of two residents reviewed for abuse. Findings include: A review of R324's progress notes revealed the following, Date: 6/8/2025 at 15:26 (4:26 PM) .Writer notified about another resident (R325) observed with hands touching in resident (324's) brief. Witness statement completed Admin (Administrator), DON (Director of Nursing) and family member notified, skin assessment completed no bruises nor redness noted. Resident currently sitting at nursing station. A review of the medical record revealed R324 admitted into the facility on 6/5/2025 with the following medical diagnoses, Anxiety Disorder, Delirium, and Insomnia. Information was not available to review on the Minimum Data Set (MDS) assessment. R324 also required staff assistance with bed mobility and transfers. On 6/10/2025 at 9:44 AM, R324 was observed sitting at the nurse's station in the view of R325. R325 was observed to be sitting on the other side of the nurse's station in close proximity of R324 with the desk observed in between the two of the residents. R325 was observed to be talking to R324. A staff member was observed to be at the nurse's station with their back to both R324 and R325. On 6/10/2025 at 9:53 AM, an interview was completed with Licensed Practical Nurse (LPN) A. LPN A reported on the day of the incident R324 and R325 were both sitting behind the nurse's station and eating lunch. LPN A reported that Certified Nursing Assistant (CNA) B was picking up the lunch trays and came and told them they observed R325 putting their hand in R324's brief. LPN A indicated CNA B separated R324 and R325 and came and told them. LPN A reported R325 was very aggressive, and they called the physician and obtained an order for Ativan (Antianxiety). LPN A reported they then called the NHA (Nursing Home Administrator), DON, Physician's, and both responsible parties. ON 6/10/2025 at 9:57 AM, an interview was conducted with CNA B. CNA B reported they were picking up the lunch trays on the day of the incident and saw R325 with their hand in R324's brief. CNA B reported both R324 and R325 were both sitting behind the nurses' station, next to each other. CNA B reported they immediately went over to R324 and R325 and separated them. CNA B reported R325 told them to f*** off and told them they could not tell them what to do. CNA B reported when R324 currently sees R325 they mention things, such as, they needed to watch out for (R325), and they were staying away from them. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/2025 at 9:17 AM, Unit Clerk C was asked if they were given any instructions regarding R324 and R325. Unit Clerk C indicated they were told to keep them an arms reach apart. On 6/11/2025 at 11:11 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked about the alleged perpetrator (R325) continually having access to R324 and interventions put in place to keep the resident safe (day 3) of the 5-day abuse investigation. The DON reported they (R324) were to be always watched and be a arms length apart. The DON was informed of the observation of R325 sitting in front of R324 talking to them, and reported they are monitoring R324, and they do not seem to be having any adverse reactions from the incident. The DON reported R324 and R325 laugh and talk throughout the day. On 6/11/2025 at 1:00 PM, an interview was conducted with Social Worker (SW) E. SW E reported they conducted a trauma evaluation on R324, but the resident was unable to fully comprehend the results due to they're cognition. A review of a facility policy titled, Abuse Prohibition noted the following, .F. Protection of Guests/Residents during the Investigation .4. When a guest/resident displays behavior against another guest/resident that is suspected abuse, the guests/residents will be separated from each other.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: On 6/9/25 between 8:45 AM-9:30 AM, during an initial observation of the kitchen with Dietary Manager F, the following items were observed: The vent hood was observed with a heavy buildup of grease. There was a sticker observed on the vent hood, noting it was last cleaned 3/26/25. Dietary Manager F stated that company comes out every 3 months to clean the vent hood. There was no cleaning schedule set up for the months in between to ensure the vent hood was cleaned more frequently. 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 were gnats observed in the dish machine room and near 3 compartment sink. The floor in the dish machine room was very wet, with standing water in wells between the tiles. There was water pooled on the floor in the corner behind the door. According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: .4. (D) Eliminating harborage conditions. There was a continuous leak from the recessed drain well on the soiled side of the dish machine. In addition, the drain pipe from the soiled side sink basin was leaking water onto the floor. The floor was extremely wet, with pooling water in several areas. When queried on 6/9/25 at 10:00 AM, Maintenance Director G stated he would have the leaks repaired right away. According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair, A plumbing system shall be: (A) Repaired according to law; P and(B) Maintained in good repair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The high temperature dish machine was checked for sanitization with an irreversible temperature indicator strip. The strip sent through the dish machine did not change color, indicating the surface temperature had not reached 160 degrees Fahrenheit. A dishwasher plate thermometer sent through the dish machine 3 times, recorded the maximum surface temperature between 145 degrees Fahrenheit and 151 degrees Fahrenheit. It was observed that the inner long curtain inside the dish machine was missing, and the short curtain at the end of the dish machine was also off. Observation of the temperature log revealed the last temperature strip had been done on 6/6/25, and the temperature of the dish machine had last been logged on 6/8/25. When queried, Dietary Manager F stated temperature strips should be run through the machine once a day, and the temperatures should be logged daily at breakfast, lunch, and dinner. Staff was observed actively doing dishes at the dish machine. Dietary Manager F instructed staff to stop using the dish machine, and stated she would call a service company. According to the 2017 FDA Food Code section 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. (A) The temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than: (1) For a stationary rack, single temperature machine, 74°C (165°F); Pf (2) For a stationary rack, dual temperature machine, 66°C (150°F); Pf (3) For a single tank, conveyor, dual temperature machine, 71°C (160°F); Pf or (4) For a multitank, conveyor, multitemperature machine, 66°C (150°F). Pf There was a wet wiping cloth lying on the food preparation counter across from the oven. There was no sanitizer bucket observed. 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 § 4-501.114; In the 1st floor kitchenette, the interior of the microwave was observed to be soiled, and the side vents on the ice machine were dusty. In addition, there was a pinkish orange slime along the bottom edge of the ice chute. The ice machine drain line observed to extend down approximately 3 inches below top of the floor drain. 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. According to the 2017 FDA Food Code section 4-602.11 Equipment Food-Contact Surfaces and Utensils, (E) Except when dry cleaning methods are used as specified under § 4-603.11, surfaces of utensils and equipment contacting food that is not potentially hazardous (time/temperature control for safety food) shall be cleaned: (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. According to the Food & Drug Administration (FDA) 2017 Model Food Code, Section 5-402.11 Backflow Prevention, (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the 2nd floor kitchenette, there was a BUNN LCA-2 coffee maker attached to the water supply line. There was no backflow protection for the water line hook-up to the coffee maker. On 6/9/25 at 11:30 AM, Maintenance Director G was queried about the lack of backflow protection for the coffee maker, and stated It's been like that for as long as I've been here. According to the Installation and Operating Guide for the BUNN LCA-2 coffee maker, As directed in the International Plumbing Code of the International Code Council and the Food Code Manual of the Food and Drug Administration (FDA), this equipment must be installed with adequate backflow prevention to comply with federal, state and local codes. For models installed outside the U.S.A., you must comply with the applicable Plumbing /Sanitation Code for your area.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to eliminate harborage conditions to maintain an effective pest control program. This deficient practice had the potential to affect all residents in the facility. Findings include: On 6/9/25 at 9:15 AM, there were numerous gnats observed in the dish machine room and near the 3 compartment sink in the kitchen. There was a continuous leak of water onto the floor, from the recessed drain well on the soiled side of the dish machine. In addition, the drain pipe for the sink basin located on the soiled side of the dish machine was leaking water onto the floor. The floor in the dish machine room was very wet, with standing water in the wells between the floor tiles. In addition, there was water pooled on the floor in the corner behind the door. On 6/9/25 at 10:15 AM, Maintenance Director G was queried about the gnats and the water leaks/pooled water in the kitchen. Maintenance Director G stated they needed to regrout the floor and stated he would get a repair company out to fix the leaking pipes. Review of the pest control service reports noted: 11/8/24 Noticed a lot of vinegar flies in the basement dish area and in the hallways where the food carts are sitting out. I suggested .to perhaps put a couple of floor fans in the dish room to dry it out .there's heavy water everywhere . 1/29/25 Water pouring out of the pipes under the dishwasher. Repair or replace as needed. 2/10/25 Floor tiles need repair/grout. Vinegar flys will breed between the missing grout lines. Seal cracks and crevices throughout the kitchen and dish room .Did find some vinegar flies underneath the kitchen 3 compartment sink. This is due to standing water along the baseboards and where there is no grout lines between the tiles in the kitchen This is a structural issue that needs to be addressed . 3/18/25 Spoke with (Maintenance) and reiterated about the standing water especially where grout lines are low and/or missing. These areas allow vinegar flys to feed and breed. 5/27/25 I did find a few dozen vinegar flies coming out from behind the tiles in the kitchen area. It is highly important that all broken tiles are replaced, and all gaps are sealed to prevent fly breeding. 6/4/25 There was still significant fly activity in the kitchen today. It is my recommendation that the deep grout lines are filled in to prevent the flies from breeding. I did also observe a significant amount of standing water in the dishwasher area on the floor.