STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235490	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of MT Pleasant	1524 Portabella Rd Mount Pleasant, MI 48858

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review, the facility failed to provide adequate smoking supervision and monitoring for 5 of 14 residents (Resident #25, #1, #27, #26, and #13) reviewed for accidents and safety. Findings: Review of the facility Acknowledgment of Facility Smoking Policy signed by residents deemed appropriate for smoking revealed, .1) Oxygen use is prohibited in smoking areas for the safety of residents. The facility will have a system for removal of the oxygen container, tubing, etc. while the resident is in a smoking area. These items will be kept at least 5 feet away from any smoking area. 2) Smoking items (Cigarettes, lighters, etc.) will be kept secured in a designated area with limited staff access. Residents shall not keep any smoking materials in resident rooms. 3) A list of smoking times will be given to those residents identified with smoking privileges. Residents will also be allowed to smoke in the designated smoking areas during off-scheduled times with a family member or visitor who is able to appropriately supervise the resident for smoking safety. 4) Only facility provided ashtrays shall be used. 5) The attending Physician and the Director of Nursing Services (DNS) shall have the authority to make the determination as to what restrictions, if any, will need to be placed on the resident's smoking privileges. 6) Any resident with smoking privileges shall not be permitted to smoke without the direct supervision of a responsible staff member, family member, visitor or volunteer worker and direct supervision must be provided throughout the entire smoking period. 7) Residents with smoking privileges will be discouraged from smoking outside during inclement weather including storms and temperature extremes. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

8) To promote safety for all residents and staff, residents with smoking privileges agree to allow staff to search the resident and resident room/belongings for smoking materials if the facility reasonable suspects smoking materials may be present in those locations. If smoking materials are located, they shall be secured in the facility designated location for smoking materials .

Resident #25 (R25)

Review of an Admission Record revealed R25 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: left and right above knee amputation, dementia, and nicotine dependence. R25 was his own responsible party/decision maker.

Resident #1 (R1)

Review of an Admission Record revealed R1 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: polyneuropathy (nerve pain), adjustment disorder with mixed anxiety and depressed mood, and chronic pain syndrome. R1 was his own responsible party/decision maker.

Review of R1's Care Plan revealed, Keep oxygen away from smoking materials. Ensure removal prior to resident smoking .Date Initiated: 09/26/2023.

Review of R1's Nursing Quarterly/Significant Change Evaluation dated 7/30/24 revealed, .Safe Smoking Evaluation- 1. Does the resident currently smoke, use e-cigarettes, or tobacco products? No .

Resident #27 (R27)

Review of an Admission Record revealed R27 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: legal blindness, difficulty in walking, intellectual disabilities, convulsions, and muscle weakness.

Review of R27's Nursing Quarterly/Significant Change Evaluation dated 6/14/24 revealed, .Safe Smoking Evaluation- 1. Does the resident currently smoke, use e-cigarettes, or tobacco products? No .

Review of R27's Electronic Health Record revealed R27 had a court appointed guardian. There was no documentation reflecting that the guardian consented to R27 smoking cigarettes or that they consented to R27 leaving the facility to smoke cigarettes unsupervised.

During an observation on 08/27/24 at 11:08 AM, R25 exited the facility through the front entrance in his motorized wheelchair and lit up a cigarette approximately 25 feet away in the center of the driveway. There were no staff, family, or visitors with him. During the observation a compact SUV drove down the driveway causing R25 to move to the sidewalk within 30 feet from the front door next to the D Wing.

At 11:10 AM, R1 exited the facility through the front doors on his motorized wheelchair with an oxygen tank attached to the back and lit up a cigarette in the garden area of the circular driveway. There were no staff, family, or visitors with him.

(continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:14 AM, R25 finished his cigarette and flicked the white cigarette filter on the woodchips outside of a resident window on the D Wing directly next to the building. There were greater than 10 white cigarette filters observed directly where R25 discarded his cigarette filter. R1 was observed nodding off (appearing sleepy, head dropped down towards his chest, and jerked awake) and then proceeded to ash his cigarette onto the woodchips in the garden area of the circular driveway. When R1 finished his cigarette, he flicked the cigarette until the ember of the cigarette fell to the pavement and unintentionally dropped the cigarette butt on the ground. R1 then stood out of his motorized wheelchair, bent over to pick up the cigarette butt causing him to stumble. R1 did not fall, obtained the butt and placed it in his cigarette container. At 11:24 AM, R1 reentered the facility. There were no staff, family, or visitors with him while he was outside smoking a cigarette. R1 did not utilize the smoking pavilion. At 11:32 AM, R25 reentered the facility. There were no staff, family, or visitors with him while he was outside smoking a cigarette. R25 did not utilize the smoking pavilion. At that time (11:32 AM), R27 exited the facility to smoke a cigarette utilizing the smoking pavilion. The pavilion did not contain a fire extinguisher or other fire suppression tools (fire blanket, fire alarm, etc). At 11:44 AM, R27 reentered the facility. There were no staff, family, or visitors present while he was outside smoking a cigarette. This writer followed R27 back into the facility. At 11:46 AM, a conversation between the front office staff and the Hospitality Aide (HA) F was heard. A front office staff member asked HA F if the smokers (R25, R1, and R27) had signed out of the book (leave of absence book/sign out sheet reflecting a residents location and the time they signed out and back in). HA F reported to the front office staff members that she was not aware that residents were required to sign out if they were not leaving the facility property and were going out to smoke. The Leave of Absence (LOA) logbook was reviewed for R25, R1, and R27 and did not reflect the date, time, and reason for exiting the building/location during the smoking observation period. HA F exited the front office and opened the LOA logbook to R27's record and confirmed that R27 did not sign himself out before exiting the building to smoke a cigarette. HA F reported that if a resident forgets/refuses to sign themselves out to smoke, then a staff member should document the date, time, and reason for leaving for the resident. At 11:54 AM, Scheduler (S) Q and Corporate Nurse (CN) R reported that staff were to keep residents smoking paraphernalia (cigarettes and lighters) locked up in the smoking cart and reported that residents that go out to smoke alone were to sign out of the LOA logbook. Resident #26 (R26) Review of an Admission Record revealed R26 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: alcohol abuse, neuropathy, and need for assistance with personal care. R26 was his own responsible party/decision maker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R26's Nursing Quarterly/Significant Change Evaluation dated 6/17/24 revealed, .Safe Smoking Evaluation- 1. Does the resident currently smoke, use e-cigarettes, or tobacco products? No . Review of R26's Care Plan revealed, .Resident will often refuse to return cigarettes to staff once done smoking. Staff to only given resident one cigarette at time, instead of entire pack Date Initiated: 08/26/2024. During an observation on 08/26/24 at 10:31 AM, R26 was in his room sitting on the side of his bed. There was a pack of cigarettes in the front pocket of his t-shirt. During an observation on 8/28/24 at 7:50 AM, R26 was exiting the facility to smoke a cigarette. R26 did not sign out of the LOA book. At 9:09 R26 was observed in his wheelchair in the hallway. Review of the LOA logbook on 8/28/24 at 9:15 AM revealed R26 was not signed out at the time he exited the facility to smoke or the time he returned related to above observation. Resident #13 (R13) Review of an Admission Record revealed R13 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: stroke affect the left side and epilepsy. R13 was her own responsible party/decision maker. During an observation on 8/28/24 at 07:50 AM, R13 exited the facility to smoke a cigarette. During an observation on 8/28/24 at 8:25 AM, R13 had returned to her room and was receiving her morning insulin. Review of the LOA logbook on 8/28/24 at 9:15 AM revealed R13 was not signed out at the time she exited the facility to smoke or the time she returned related to above observation. During an interview on 8/28/24 at 8:11 AM, Registered Nurse (RN) J reported that resident cigarettes were to be locked up in the smoking cart and residents were to sign themselves out of the LOA logbook if they were going out to smoke independently. During an interview on 08/28/24 at 02:02 PM, NHA confirmed that R1, R26, and R27's Safe Smoking Evaluations were not completed per the facility policy due to incorrect documentation (documented that they were non-smokers). NHA reported that the Director of Nursing would update the Safe Smoking Evaluations for R1, R26, and R27 by the end of the day. During an interview via email on 08/28/24 at 01:42 PM, Nursing Home Administrator (NHA) stated, (R27's) guardian (name omitted) is aware that he smokes and that he goes out alone. In the past she has not had any concerns related to this. My Social Worker (name omitted) called the office today to reconfirm that it's still okay that he does this. There remain no concerns. Confirming there was no documented consent to smoke by R27's guardian. Review of R27's Physician Progress Note dated 8/28/24 revealed, This author contacted (guardian name omitted) voluntary guardian and reconfirmed that (R27) can leave the facility independently if or shopping, banking and independent smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Smoking Safety last revised 11/28/17 (provided in the resident smoking binder on 8/27/24) revealed, . 1. The facility will have a designated smoking area for residents in accordance with Federal, State and other entities having jurisdiction laws. This area must be one that does not infringe upon the rights of the non-smoker. 2. Designated smoking areas will be equipped with a fire extinguisher which will be mounted in an area to allow free access by staff. 3. Smoking areas will have ashtrays made of noncombustible material and safe design as well as metal containers with self-closing covers into which ashtrays will be emptied at the conclusion of smoking sessions . 4. Oxygen use is prohibited in smoking areas for the safety of residents. The facility will have a system for removal of the oxygen container, tubing, etc. while the resident is in a smoking area. These items will be kept at least 5 feet away from any smoking area. 5. Smoking items (cigarettes, lighters, etc.) will be kept secured in a designated area with limited staff access. 6. All residents will be screened as part of the admission evaluation for smoking practices . 8. Each resident who chooses to smoke will be assessed to determine smoking safety. This may include, but not be limited to: *Cognitive patterns and safety awareness *Communication/hearing/vision *Physical abilities/deficits *Observations of the resident's physical and cognitive abilities 9. The smoking assessment will be completed upon admission, quarterly, with a significant change in status related to smoking, or anytime the facility determines it is warranted . 11. A comprehensive plan of care will be developed in conjunction with the Resident Assessment Instrument process . 13. Residents who smoke will have their specific interventions identified on the resident Kardex for staff review . Review of the facility policy Smoking Policy Smoking Campus-Residents dated July 2017 (provided in the resident smoking binder on 8/27/24) revealed, .5. Any resident with smoking privileges shall not be permitted to smoke without the direct supervision of a responsible staff member, family member, visitor or volunteer worker and direct supervision must be provided throughout the entire smoking period . 1. Smoking privileges shall be reviewed at least quarterly by the Director of Nursing Services, the Attending Physician, and/or the Care Planning Team. 2. A list of smoking times will be given to those residents identified with smoking privileges. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Residents will be allowed to smoke, in the designated smoking area, during off-scheduled times with a family member or visitor. The family member/visitor must agree to stay with the resident during the entire smoking period . 1. This facility shall have the authority to make periodic checks to determine if residents have any smoking articles that are in violation of our smoking regulations .

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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** 39056 Based on observation, interview, and record review, the facility failed to assess, monitor, and care for a resident receiving tube feedings per facility policy and professional standards of care for 1 of 3 residents (Resident #61) reviewed for the care of tube feedings. Findings: Resident #61 (R61) Review of an Admission Record revealed R61 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: adult failure to thrive and dysphagia (difficulty swallowing). Review of R61's Order Summary dated 7/15/24 revealed, Enteral Feed Order every day and night shift Check tube placement prior to administration of medications & tube feeding/flush. During an observation on 08/27/24 at 12:08 PM, Registered Nurse (RN) H had prepared medication to administer to R61 via his peg tube (feeding tube). RN H did not assess R61's gastric residual or peg tube placement. RN H then drew up the medication in a syringe (approximately 60 ml of liquid), connected the syringe to the peg tube port/adapter, and firmly pushed the plunger of the syringe until the medication was administered (less than 15 seconds). RN H did not remove the plunger of the syringe, connect the open syringe to the feeding tube port/adapter, and pour the water into the syringe allowing the water to flow in utilizing gravity. During an interview on 8/27/24 at 7:15 AM, RN S reported that the placement of a feeding tube and gastric residual should be assessed prior to the administration of medications and water boluses. During an interview on 8/28/24 at 8:22 AM, RN K reported that medication administration and water boluses should be administered using gravity and should not be pushed. RN K reported that the placement of a feeding tube is assessed prior to administering medications by using the syringe to inject air into the feeding tube while listening for a gurgling sound with a stethoscope of the peg tube site. During an interview on 8/28/24 at 7:10 AM, RN J reported that the placement of a feeding tube and gastric residual should be assessed prior to the administration of medications and water boluses. RN J reported that medication administration and water boluses should be administered using gravity and should not be pushed. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 2:07 PM, Director of Nursing (DON) reported that the licensed nurses were expected to follow the facility policy and procedures when administering medications via peg tube. DON was notified that the facility policy did not reflect how licensed nurses were to assess peg tube placement. DON reported she would review the policy and provide documentation of the procedure the facility nurses were to follow. DON did not provide clarification to the facility's procedural guidelines/policy verbally or in writing prior to survey exit (8/28/24 at approximately 5:00 PM). During an interview on 08/28/24 at 03:30 PM, Corporate Nurse (CN) R reported that unless otherwise ordered, licensed nurses should allow medications and water boluses to flow by gravity when utilizing the peg tube. CN R reported that she had recently updated the facility policy and procedures regarding the assessment of peg tube placement due to the change in the standards of practice and was waiting on corporate's (upper managements) approval to implement the changes and educate the licensed nurses. Review of the facility policy Feeding Tubes last reviewed/revised 6/30/22 revealed, .10. In accordance with facility protocol, licensed nurses should: a. Monitor and check that the feeding tube is in the right location (e.g., stomach or small intestine, depending on the tube) b. Tube Placement will be verified before beginning a feeding and before administering medications . 12. Direction for staff regarding how to manage and monitor the rate of flow will be provided: a. Use of gravity flow. b. Use of a pump . Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, PROCEDURAL GUIDELINES Administering Medications Through an Enteral Tube (Feeding Tube) .10. Before administration of enteral medications, verify placement of feeding tube according to agency policy and determine that tube is placed in the stomach or small intestine correctly .22. Check for gastric residual volume (GRV). Draw up 10 to 30 mL of air into a 60-mL syringe and connect syringe to feeding tube. Flush tube with air and pull back slowly to aspirate gastric contents . 25. Administer dose of first liquid or dissolved medication by pouring into syringe. Allow to flow by gravity. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 651-652). Elsevier Health Sciences. Kindle Edition. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Historically nurses confirmed placement of feeding tubes by injecting air into the tube while auscultating the stomach for a bubbling or gurgling sound or by asking the patient to speak. Current evidence shows that these methods are ineffective in verifying tube placement. Currently, the most accurate method for verification of tube placement is x-ray film examination. At the bedside, nurses test the pH of secretions withdrawn from the feeding tube to confirm tube location on an ongoing basis .PROCEDURAL STEPS: Review agency policy and procedures for frequency of irrigation and frequency and method of checking tube placement. Do not insufflate air into tube to check placement .CLINICAL JUDGMENT: Listening for insufflated air instilled through tube to check tube tip position is unreliable . [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1198-1199). Elsevier Health Sciences. Kindle Edition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) and Transmission Based Precautions (TBP) were in place and followed for 3 residents (Resident #64, #217, and #21) of 4 residents reviewed for Precautions, resulting in the increased potential for cross-contamination, bacterial harborage and spread of infection throughout the facility. Findings include: Resident #64 Review of an Admission Record revealed Resident #64 (R64) admitted to the facility on [DATE] with pertinent diagnoses which included nontraumatic intracranial hemorrhage, hemiplegia (paralysis on one side of the body), and dysphagia (difficulty swallowing). Review of R64's Physician's Orders, started 7/26/2024, revealed she received enteral feeding (intake of food via the gastrointestinal tract) through a gastric tube. In an observation on 8/26/2024 at 11:10 AM, Certified Nursing Assistant (CNA) A and CNA B entered R64's room, transferred R64 from her geriatric chair to her bed, changed her brief, and transferred her back into her geriatric chair without donning a gown. There was no signage on R64's door to notify staff that she required EBP's. In an interview on 8/27/2024 at 2:12 PM, Registered Nurse (RN) Unit Manager D reported R64 required EBP because of her gastric tube and should have signage on her door to notify staff of required Personal Protective Equipment (PPE). In an observation and interview on 8/28/2024 at 9:07 AM, R64's room door had EBP signage directing staff to use a gown and gloves with high contact activities such as dressing, bathing, transferring, changing linens, providing hygiene, and changing briefs. CNA B reported the EBP signage was new and placed the day before as R64 required this because of her gastric tube. Review of R64's Electronic Health Record (EHR) on 8/28/2024 at 9:10 AM revealed no active Physician's Order for EBP's. In an interview on 8/28/2024 at 9:19 AM, RN Unit Manager D reviewed R64's EHR and reported there was no Physician's Order or Care Plan intervention for EBP's. RN Unit Manager D reported R64 should have a Physician's Order and a corresponding Care Plan intervention for EBP's. Review of facility policy/procedure Enhance Barrier Precautions, revised 3/26/2024, revealed .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . employs targeted gown and gloves use during high-contact resident care activities . enhanced barrier precautions will be obtained for residents with any of the following . wounds . indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #217 Review of an Admission Record revealed Resident #217 (R217) admitted to the facility on [DATE] with pertinent diagnoses which included right femur fracture and enterocolitis due to clostridium difficile (C-diff). Review of a current C-diff Care Plan intervention for R217, initiated 8/23/2024, directed staff to use contact isolation precautions. Review of R217's Physician's Orders, active 8/26/2024, revealed she was in contact precautions related to C-diff infection. In an observation on 8/27/2024 at 11:16 AM, 2 CNA's removed a gown and gloves after providing care to R217 in her room and performed hand hygiene using hand sanitizer. They did not wash their hands with soap and water after providing care. In an interview on 8/27/2024 at 1:44 PM, the Director of Nursing (DON) reported staff were required to wash hands with soap and water instead of using hand sanitizer when caring for residents in contact isolation for C-diff. The DON reported she would educate staff regarding this. In an observation on 8/28/2024 at 9:00 AM, R217's room door had signage that read .wash hands on way in with soap and water. Wash hands on way out with soap and water . In a telephone interview on 8/28/2024 at 10:10 AM, CNA C reported she was working with Resident #217 the morning of 8/27/2024. CNA C reported she was educated on 8/28/2024 that she was required to wash hands with soap and water instead of using hand sanitizer when caring for residents with C-diff. CNA C stated, I was not doing this right before. Review of facility policy/procedure Transmission-Based (Isolation) Precautions, revised 12/27/2023, revealed .It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission . An order for transmission-based precautions/isolation will be obtained . Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room . Type and Duration of Transmission-Based Precautions Recommended for Selected Infections and Conditions . Clostridioides difficile, formerly known as Clostridium difficile . precaution . contact . duration . duration of illness . comments . hand hygiene with soap and water . In an interview on 8/28/2024 at 11:20 AM, the DON reported Resident #21 was tested early that morning for C-diff. The DON reported he should be in contact isolation until test results returned negative. The DON reported she had not yet placed signage on Resident #21's door regarding the need for staff to wash hands with soap and water instead of using hand sanitizer. In an interview on 8/28/2024 at 11:38 AM, Housekeeping Supervisor P reported he typically found out about residents in isolation at the morning team meetings. Housekeeping Supervisor P reported he was not aware Resident #21 was being tested for C-diff until the DON notified him just a few minutes ago. 39056 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medilodge of MT Pleasant		STREET ADDRESS, CITY, STATE, ZIP CODE 1524 Portabella Rd Mount Pleasant, MI 48858	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the Centers for Disease Control and Prevention (CDC), .Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html (Article dated 4/3/24). Per the Centers for Disease Control and Prevention (CDC), .C. diff sheds in feces. Any surface, device or material that becomes contaminated with feces could serve as a reservoir for the C. diff spores. Examples include: *Commodes *Bathtubs . C. diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item. *Isolate patients with possible C. diff immediately, even if you only suspect CDI (clostridium difficle infection) . https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html (Article dated 3/5/24). Resident #21 (R21) Review of an Admission Record revealed R21 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: acute osteomyelitis of the right ankle and foot (requiring the long-term use of intravenous antibiotics). Review of R21's Nurses' Note dated 8/19/24 revealed, Resident tested positive for COVID 19 . During an observation on 08/26/24 at 10:44 AM, the door to R21's room was closed with a sign posted. The sign contained the following: TRANSMISSION BASED PRECAUTIONS-What you should be wearing before entering room: N95 Mask .Gown .Gloves .Face Sheild. The sign did not indicate the type of Transmission Based Precaution (TBP) R21 was in (contact, droplet, and/or airborne). Review of R21's Provider Note dated 8/28/24 revealed, Notified by nursing that patient has watery brown stools, c/o (complaints of) generalized abd (abdominal) pain. No fever, + chills x once. Meds reviewed, patient is on IV antibiotic. Orders given to obtain stool for c-diff (Clostridium difficile) . Review of R21's Nurses' Note dated 8/28/24 at 1:07 AM revealed, Provider notified resident is having increased abdominal pain and watery brown stools since Sunday (8/25/24). Resident was diaphoretic [NAME] asleep .Orders received for stool for c diff . Per the CDC, R21 should have been placed in contact isolation at this time. Review of R21's Pertinent Charting-Infections/Signs Symptoms note dated 8/28/24 at 5:31 AM revealed, Site of originally identified infection: right foot wound .lab work and c diff stool sample being sent. Review of R21's Order Summary dated 8/28/24 at 01:51 AM revealed, stool for diff (Clostridium difficile) x 1 one time only for water stool . Review of R21's Medication/Treatment Administration Record revealed the c-diff stool sample was obtained on 8/28/24 at 4:13 AM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 08/28/24 at 10:30 AM, the door to R21's room was closed with a sign posted. The sign contained the following: TRANSMISSION BASED PRECAUTIONS-What you should be wearing before entering room: N95 Mask .Gown .Gloves .Face Sheild. The signage did not reflect that contact precautions were to be implemented (contact precautions required for c. diff.) During an interview on 08/28/24 at 11:35 AM, Director of Nursing (DON) was notified that R21's door signage did not reflect contact precautions. DON reported she would ensure signage that reflected R21's presumptive positive c. diff infection. During an observation on 08/28/24 at 2:45 PM, the door to R21's room was closed with the same sign observed at 10:30 AM along with an additional printout posted reading wash hands with soap and water going into room and leaving room. There was no signage indicating R21 was in contact precautions in order for staff to ensure proper infection control practices were followed. During an interview on 8/28/24 at 10:34 AM, Laundry Staff (LS) M reported R21 was in isolation for COVID-19. During an interview on 8/28/24 at 10:40 AM, Certified Nursing Assistant (CNA) I reported R21 was in isolation for COVID-19 only. During an interview on 8/28/24 at 10:44 AM, Unit Manager (UM) N reported R21 was in isolation for COVID-19 and would be taken out of isolation on 8/29/24. UM N did not indicate that he was placed in contact isolation at the time c. diff was suspected. R21's Order Summary Report was reviewed on 8/28/24 at 2:45 PM and revealed an order for Enhanced Barrier Precautions (EBP) related to acute osteomyelitis and transmission-based precautions related to positive or suspected COVID-19 status. There was no order for contact precautions related to the presumptive positive c. diff infection. Resident #36 (R36) Review of an Admission Record revealed R36 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: a stroke and the use of a gastrostomy tube (feeding tube). R36 was ordered to be in EBP due to his feeding tube and his tracheostomy. Review of R36's Order Summary dated 2/29/24 revealed, every 4 hours .Flush (gastrostomy) tube with (335) ML's H20 (water) . Water bolus/flush to be administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM (6 times a day). During an observation on 08/28/24 at 11:20 AM it was identified that R21 and R36 had a shared bathroom. There was no signage on the door to the bathroom from R36's room indicating that R21 was in contact precautions for a c. diff infection. At 11:22 AM an attempt was made to open R36's bathroom door. The door was unlocked but R21 was sitting on the toilet having a bowel movement at that time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/24 at 11:33 AM, RN K reported that the facility practice was for nurses to fill a graduated cylinder with tap water from R36 and R21's shared bathroom sink to administer the every 4 hour ordered flushes. RN K reported R21 was in isolation for COVID-19 and had not been notified of any other type of isolation precautions for R21. During an observation on 08/28/24 at 12:33 PM, RN K donned PPE per R36's ordered EBP and entered his room. RN K brought R36's graduated cylinder to R36 and R21's shared bathroom sink and filled it with tap water. There was a smear of feces noted on the bathroom floor near the toilet and the toilet contained fecal waste and used toilet paper. RN K connected a syringe (with no plunger) to the feeding tube port/adapter and poured the tap water from the graduated cylinder into the open syringe, administering the ordered amount of the water bolus/flush. RN K then capped off the feeding tube port/adapter and set the graduated cylinder back down in R36's room. Review of R36's Medication Administration Record revealed that on 8/28/24 R36 was administered a water bolus/flush at 4:00 AM, 8:00 AM, and 12:00 PM (R21's order for stool testing for c. diff was documented on 8/28/24 at 1:07 AM and contact precautions were not implemented). Indicating 3 times that R36 was exposed to c. diff spores from the nurse touching the contaminated surfaces in the bathroom, holding the graduated cylinder and syringe, and connecting the syringe directly to the feeding tube port. During an interview on 8/28/24 at 2:47 PM, R21 was not in his room. Housekeeping Staff (HS) L was in R21's room and reported that he was informed about an hour and a half ago that R21 was being tested for c. diff and was directed by management to clean R21's room and bathroom following the most severe protocol (terminal cleaning per the CDC guidelines to kill c. diff spores). During an interview via email on 08/28/24 at 1:30 PM, Nursing Home Administrator (NHA) stated, It (stool sample) was sent to (laboratory name omitted) this morning. They sent it out for processing and stated at the earliest it would be this afternoon or evening; tomorrow if not today. As of 08/28/24 at 4:45 PM the Clostridium difficile stool sample had not been resulted by the laboratory. R21's Clostridium difficile status was unknown and therefore presumed positive per the CDC. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Antibiotic use alters the normal flora in the GI tract. A common causative agent of diarrhea is Clostridium difficile (C. difficile), which produces symptoms ranging from mild diarrhea to severe colitis. The Infectious Diseases Society of America (IDSA) identified C. difficile as the most common health care-related infection in America. Patients acquire C. difficile infection in one of two ways: by antibiotic therapy that causes an overgrowth of C. difficile and by contact with the C. difficile organism. Patients are exposed to the organism from a health care worker's hands or direct contact with environmental surfaces contaminated with it. Only hand hygiene with soap and water is effective to physically remove C. difficile spores from the hands. Older adult patients are especially vulnerable to C. difficile infection when exposed to antibiotics, and higher mortality and morbidity are observed in this age-group .To decrease the spread of infection, patients with C. difficile are placed on contact/enteric isolation precautions. A private room with a dedicated toilet is preferred to help prevent transmission to other patients. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 1278-1279). Elsevier Health Sciences. Kindle Edition.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to administer the pneumococcal and influenza vaccination to 1 resident (Resident #29) of 5 residents reviewed for immunizations, resulting in the potential for residents to contract and spread preventable diseases. Findings include: Resident 29 Review of an Admission Record revealed Resident #29 (R29) admitted to the facility on [DATE] with pertinent diagnoses which included dementia and peripheral vascular disease. Further review revealed R29 had an activated medical Power of Attorney (POA). Review of a Minimum Data Set (MDS) assessment for Resident #29, with a reference date of 8/1/2024 revealed a Brief Interview for Mental Status (BIMS) score of 1, out of a total possible score of 15, which indicated Resident #29 was severely cognitively impaired. Review of R29's immunization record revealed the facility documented he refused the influenza and pneumococcal vaccinations. In an interview on 8/27/2024 at 1:44 PM, the Director of Nursing (DON) reported R29's POA consented to the influenza and pneumococcal vaccinations but could not find documentation that these were administered or refused. Review of R29's Influenza Vaccine Consent Form revealed his POA consented to the influenza vaccine on 11/7/2023. Review of R29's November 2023 Medication Administration Record revealed the influenza vaccine was ordered and scheduled to be given on 11/9/2023 or 11/10/2023 and the boxes were blank, indicating the vaccination was neither given nor refused. In an interview on 8/28/2024 at 10:20 AM, the DON reported she was unable to find documentation that R29 had received or refused the influenza and pneumococcal vaccinations. Review of facility policy/procedure Influenza Vaccination, revised 10/26/2023, revealed .It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza . Review of facility policy/procedure Pneumococcal Vaccine (Series), revised 10/30/2023, revealed .It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations .