STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235515	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Manor Healthcare Center	408 N Fifth Ave Tawas City, MI 48763

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 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** 37668 Based on observation, interview and record review, the facility failed to implement a care plan related to supplemental oxygen use for one resident (Resident #44) of two residents reviewed for respiratory care. Findings include: Resident #44: On 3/25/25 at 11:06 AM, Resident #44 was observed in their room in bed. The Resident was receiving supplement oxygen via Nasal Cannula (NC) at a rate of 2 liters (L) per minute. At 3:42 PM on 3/26/25, Resident #44 was observed in their room. The Resident was in bed and receiving supplemental oxygen at 2L/minute via NC. Record review revealed Resident #44 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included bladder cancer, depression, bipolar disorder, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to total assistance for toileting, transferring, and hygiene. The MDS further detailed the Resident was receiving oxygen therapy. Review of Resident #44's care plans revealed the Resident did not have an active and/or discontinued care plan pertaining to oxygen therapy and/or respiratory care. Review of Resident #44's Health Care Provider (HCP) orders revealed the order, Oxygen 2L via nasal cannula. as needed for SOB (Shortness of Breath) dated 1/25/25. An interview was completed with the facility Administrator on 3/27/25 at 1:58 PM. When queried if Residents receiving oxygen therapy should have a care plan in place, the Administrator verbalized they should. When asked if Resident #44 had a care plan related to oxygen therapy, the Administrator reviewed Resident #44's EMR and confirmed the Resident did not have a care plan pertaining to oxygen therapy. The Administrator indicated they would discuss with the MDS nurse to ensure a care plan was implemented.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to timely update/revise individualized, person-centered care plans to reflect changing care needs for 3 residents (Residents #11, Resident #16 and Resident #111). Findings include: Resident #11: Observation on 03/25/25 at 10:38 AM during the survey screening process the surveyor observed Resident #11 to be lying in bed and thin in appearance. Observation and interview on 03/25/25 at 01:06 PM with Resident #11 revealed that she did get lunch (while still lying in bed), she had Lost some weight, but that she was not hungry. Observation on 03/25/25 at 01:08 PM of Resident #11's meal tray in the meal tray brown box revealed 3/4 of tray was eaten. Record review on 03/25/25 at 02:47 PM of Resident #11's weight log documentation revealed: On 1/21/2025 resident #11's weight was 136.2 pounds and on 2/25/2025 weight of 123.5 equaled a 12.7-pound weight loss in 35 days of 9.32% loss. Record review of Resident #11's care plans pages 1-56 revealed alteration for nutrition initiated 11/27/2024. Revision of nutritional alteration care plan dated 2/12/2025 revealed 120 ml Med Pass 2.0 twice daily was added. On 3/6/2025 the Certified Dietary Manager (CDM) revision but made no changes to the interventions even with additional 12.7-pound weight loss noted on 2/25/2025. Resident #16: Observation on 03/25/25 at 08:57 AM Resident #16 was seated up in wheelchair in her room and was thin in appearance. Observation and interview on 03/25/25 at 01:12 PM with Resident #16 revealed that she went to the dining room in via self-propel in wheelchair. Resident #16 was observed getting herself back to her room. Record review on 03/25/25 at 02:40 PM of Resident #16's electronic medical Record review of resident documented weight log revealed: On 1/21/2025 resident #16 weight was 189.5 pounds and on 3/24/2025 residents' weight was 178.0 pounds that is a 11.5-pound loss or 6.07% loss in 60 days. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #16's care plans pages 1- 63 with revision date 3/9/2025. Record review of the dietary interventions revealed: Provide diet as ordered: Consistent Carbohydrate diet, puree texture, pudding thickened fluids. Enriched/fortified foods, revision by CMD O revision date of 2/20/2025. There were no other interventions since the 2/20/2025 revision date for the 10.4-pound weight loss. Review of the facility Care Planning policy dated 3/3/25, revealed person centered care plans are to be prepared (done) by the interdisciplinary team (all members of the team, including nurse responsible for the resident). Resident care plans are triggered based on the needs and/or potential needs. 22347 Resident #111: Review of the Face Sheet, physician, nurses progress notes, physician orders and care plans dated 6/23 to 3/25, revealed Resident #111 was [AGE] years old, alert, admitted to the facility on [DATE], and required assistance with all Activities of Daily Living. The resident's diagnosis included, Bipolar Disorder, anemia, cognitive impairment, Anxiety Disorder, heart failure, Atrial Fibrillation, muscle weakness, Dysphagia, chronic lung disease, diabetes and chronic kidney disease. The resident had a history of loose stools and incontinence. Review of the residents facility Skin assessment dated [DATE], stated small area of excoriation/red area left gluteal fold/crease. Observation done on 3/26/25 accompanied by MDS Nurse at 9:10 am of residents coccyx area, revealed skin intact, with no signs of pressure ulcers. The residents peri area was red, excoriated and tender with complaints of pain and discomfort. Review of all the residents facility care plans with MDS Nurse, LPN F on 3/26/25 at 9:00 a.m., revealed no documentation of an actual skin impairment care plan; only an at risk for skin impairment care dated 6/21/23. The resident did have actual skin impairment and redness; no up-date to the at risk for skin impairment or actual skin impairment care plan was found. During an interview done on 3/26/25 at 9:20 a.m., the Director of Nursing stated The nurses (floor nurses) would do the care plans. During an interview done on 3/26/25 at 9:51 a.m., Education Nurse, RN D stated During orientation I do educate them on care plans. They don't up-date them, we (managers) usually do it. They are supposed to be up-dating care plans. Review of the facility nursing orientation sheet (un-dated) revealed documentation of education on care plans. Review of the facility Care Planning policy dated 3/3/25, revealed person centered care plans are to be prepared (done) by the interdisciplinary team (all members of the team, including nurse responsible for the resident). Resident care plans are triggered based on the needs and/or potential needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Skin Management policy dated 9/14/24, revealed the licensed nurse will document preventive measures on the care plan/Kardex; the DON (Director of Nursing)/designee will document any changes in the care plan/Kardex at the meeting (Resident at Risk Meeting).

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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** 37668 Based on observation, interview and record review, the facility failed to implement planned interventions for pressure ulcer (wounds caused by pressure) prevention for one resident (Resident #23) of six residents reviewed. Findings include: Resident #23: On 3/25/25 at 9:52 AM, Resident #23 was observed in their room in bed. The Resident was in bed, positioned on their back and covered in a blue blanket. The blue blanket was visibly soiled with scattered areas of an unknown brown colored substance. Their left knee was bent, and their right leg was straight. A heel boot (soft boot to refuse pressure) was in place on the Resident's right lower extremity only. When spoke to, Resident #23 made eye contact but did not provide meaningful, verbal responses. A second heel boot was observed on the top and back corner of the Resident's armoire/closet behind their room door. Record review revealed Resident #23 Electronic Medical Record (EMR) revealed the Resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, depression, anxiety, bipolar disorder, and chronic pain. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required maximum to total assistance to complete Activities of Daily Living (ADL's) with the exception of eating. The MDS further detailed the Resident was at risk for pressure ulcer development and was receiving Hospice services. Further review of Resident #23's EMR revealed the Resident had developed a pressure ulcer at the facility which had healed. Review of Resident #23's EMR revealed a care plan entitled, (Resident #23) is at risk for impaired skin integrity/pressure injury R/T (related to): mobility deficit, Alzheimer's disease, bowel and bladder incontinence, and weakness . unable to verbalize or sense need for toileting (Initiated: 5/24/24; Revised: 6/8/24). The care plan included the intervention, Encourage to wear soft Prafo (heel) boots on in bed and in chair. (Resident #23) will refuse at times (Initiated: 6/12/24; Revised: 3/20/25). On 3/27/25 at 8:31 AM, Resident #23 was observed in their room. The Resident was in bed, positioned on their back with their eyes closed and mouth open. The room lights were off, the window shades were down, and the TV on. The Resident's right leg was straight, and their left leg was bent at the knee at approximately a 140-degree angle. The Resident had a heel boot in place on their right foot but not on their left. A second heel boot remained in the same place on top of the Resident's armoire/closet in the back behind their room door. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Registered Nurse (RN) N on 3/27/25 at 8:55 AM. When asked if Resident #23 should have heel boots in place for pressure prevention, RN N stated, I'm not sure and indicated they thought Resident #23 only had one heel boot due to contractures. An observation of Resident #23 and their room was completed with RN N at this time. RN N confirmed the Resident only had one heel boot in place. RN N began looking in the Resident's room including in the armoire/closet and verbalized they did not see a second heel boot in the room. The second heel boot on the top of the armoire/closet in the back was pointed out to RN N. RN N attempted to get the heel boot from the top of the armoire/closet but was unable to reach the item. Upon exiting Resident #23's room with RN N at 8:59 AM on 3/27/25, Wound Care Licensed Practical Nurse (LPN) B was observed in the hallway and an interview was completed. When asked if Resident #23 is supposed to have heel boots in place on one or both lower extremities, LPN B stated, Supposed to have both boots on. An observation of Resident #23's room was completed with LPN B at this time. LPN B confirmed Resident #23 only had one heel boot in place on their right lower extremity. When asked if the heel boots were termed Prafo boots in the Resident's care plan, LPN B verbalized they were. The second heel boot, on the top in the back of the armoire/closet was pointed out to LPN B. When asked about the location of the heel boot on the armoire/closet, LPN B attempted to reach to heel boot and confirmed it was not within reach. LPN B indicated it appeared as if the staff threw the heel boot on top of the armoire/closet. LPN B was observed attempting to get the heel boot down and was unable to reach the device. LPN B stated, I have other ones. When queried regarding other observation of the Resident only wearing one heel boot and the second heel boot location on the top and back of armoire/closet in the room, LPN B stated, Does have a care plan that will refuse to wear the heel boots. When asked how staff are attempting to place both heel boots on the Resident when the heel boot has been in the same place on the top and back of the armoire/closet on more than one day/observation, LPN B was unable to provide an explanation. An interview was completed with the facility Administrator on 3/27/25 at 1:58 PM. When queried regarding observations of Resident #23 only having one heel boot in place, staff interviews, and the location of the heel boot in the room, the Administrator did not provide further explanation.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to ensure to complete urinary catheter care per professional standards of practice for one resident (Resident #41). Findings include: Resident #41: Record review of Resident #41's Minimum Data Set (MDS) dated [DATE] revealed a male resident with Brief Interview of Mental Status (BIMS) score of 15 out of 15, cognitively intact. Medical diagnosis included anemia, coronary artery disease, hypertension, neurogenic bladder, diabetes and depression. Section H: Bladder & Bowel identified indwelling urinary catheter. Observation made on 03/25/25 at 09:24 AM of Resident #41, who was lying in bed with the room door open to the hallway. State surveyor observed urine catheter bag off the floor hanging out of a blue bag with the spout hanging down on the floor visible from the doorway. Observation of Resident #41's wound vac and tubing visible from doorway with dark fluid noted in tubing hanging down from the bed frame railing. Resident #41 stated that 'they (staff) hang it on the side by the door because it's easier to empty for them'. Observations and interview on 03/25/25 at 11:32 AM of Resident room with room door is open to the hallway. Housekeeper Q was cleaning rooms on 200 hallways. and stated that she already had cleaned Resident #41's room. Interview and Observation on 03/25/25 at 11:35 AM with Resident #41 stated that he got the (Urinary) catheter a while ago, and did not know when it was changed last. Observation of Resident #41's urinary catheter had the spout laying on the floor and estimated 300 clear yellow solution noted in the catheter bag and tubing. Observation and interview on 03/25/25 at 11:38 AM with Registered Nurse (RN) D the state surveyor requested nurse go to Resident #41's room with surveyor to observe the urinary catheter was hanging out from under the privacy bag and the surveyor pointed it out. RN D stated that should not be that way (hanging down out of the bag). In an interview with Resident #41 on 03/25/25 at 11:39 AM stated when asked about his catheter that he did not want everyone to know that he had it, but that he did feel better in the blabber area with it in place. Record review of the facility 'Catheter Associated Urinary Tract Infection Prevention' policy dated 2/28/2025 revealed the policy was to ensure appropriate technique in the care and maintenance of indwelling catheters. (9.) Keep the collection bag and tubing off the floor. (11.) Empty the collecting bag regularly using separate, clean container for each guest/resident. Avoid splashing, and ensure the drainage spigot does not contact the non-sterile collecting container .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. 22927 Based on observation, interview and record review, the facility failed to ensure that weights were done accurately for two residents (Resident #11 & Resident #16). Findings include: Resident #11: Observation on 03/25/25 at 10:38 AM during the survey screening process the surveyor observed Resident #11 to be lying in bed and thin in appearance. Observation and interview on 03/25/25 at 01:06 PM with Resident #11 revealed that she did get lunch (while still lying in bed), she had Lost some weight, but that she was not hungry. Observation on 03/25/25 at 01:08 PM of Resident #11's meal tray in the meal tray brown box revealed 3/4 of tray was eaten. Record review of Resident #11's documented weights revealed that on 2/10/2025 at 12:49 PM weight was 129.0. Weight on 2/25/2025 at 3:09 PM was 123.5. The weight loss of 5.5 pounds was not reweighed again until 3/4/2025 at 2;01 PM of 123.5. Record review on 03/25/25 at 02:47 PM of Resident #11's weight log documentation revealed: On 1/21/2025 resident #11's weight was 136.2 pounds and on 2/25/2025 weight of 123.5 equaled a 12. 7-pound weight loss in 35 days of 9.32% loss. In an interview and record review on 03/26/25 at 12:37 PM with Certified Dietary Manager (CDM) O reviewed the electronic medical record with the surveyor of Resident #11's documented weights. CDM O revealed that the facility weight policy was upon admission, and once a week for four (4) weeks, and then if stable the resident is changed to monthly, if not resident was kept on weekly weights. CDM O stated that Nutritional assessments must be done within 7 days of admission, nutritional risk screen was done at 5 days of admission. When there was a Change in residents' weight, the Minimum Data Set (MDS) nurse tells me there is a significant weight change. A Significant weight is 5 pounds or more in a week. Record review of Resident #11's nutritional progress notes revealed only one note dated 2/12/2025 at 1:20 PM by the Registered Dietitian was the only note that referred the resident to the Interdisciplinary for weight loss. Record review of Resident #11's care plans pages 1-56 revealed alteration for nutrition initiated 11/27/2024. Revision of nutritional alteration care plan dated 2/12/2025 revealed 120ml Med Pass 2.0 twice daily was added. On 3/6/2025 the Certified Dietary Manager (CDM) revision but made no changes to the interventions even with additional 12.7-pound weight loss noted on 2/25/2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of the facility 'Weight Management' policy dated 9/22/2023 revealed residents will be monitored for significant weight changes on a regular basis . Anticipated Outcome: any resident with unintended weight loss/gain will be evaluated by the interdisciplinary team and interventions will be implemented to prevent further wight loss/gain. Practice guidelines: (3.) Re-weights are initiated for five-pound variance if the resident is greater than 100 pounds and three-pound variance if less than 100 pounds. If a resident's weight is less than 200 pounds a re-weight will be done for a weight loss or gain of 3% or consult with the dietary manager or Registered Dietitian/designee. Re-weights will be done within 48-72 hours. Resident #16: Observation on 03/25/25 at 08:57 AM Resident #16 was seated up in wheelchair in her room and was thin in appearance. Observation and interview on 03/25/25 at 01:12 PM with Resident #16 revealed that she went to the dining room in via self-propel in wheelchair. Resident #16 was observed getting herself back to her room. Record review on 03/25/25 at 02:40 PM of Resident #16's electronic medical Record review of resident documented weight log revealed: On 1/21/2025 resident #16 weight was 189.5 pounds and on 3/24/2025 residents' weight was 178.0 pounds that is a 11.5-pound loss or 6.07% loss in 60 days. Interview and record review on 03/26/25 at 12:51 PM with Certified Dietary Manager (CDM) O reviewed the electronic medical record with the surveyor of Resident #16's documented weights revealed that the resident weight on 2/17/2025 of 186.6 pounds and then in 24 days and documented weight of 176.2 pounds on 3/13/2025 was noted. That was a weight loss of 10.4 pounds. The CDM O was asked about nutritional notes dated 3/24/2025 with no new interventions added to care plan. The CDM O stated that would be the Registered Dietitian consultants note. Record review of Resident #16's care plans pages 1- 63 with revision date 3/9/2025. Record review of the dietary interventions revealed: Provide diet as ordered: Consistent Carbohydrate diet, puree texture, pudding thickened fluids. Enriched/fortified foods, revision by CMD O revision date of 2/20/2025. There were no other interventions since the 2/20/2025 revision date for the 10.4-pound weight loss. 37668

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 22927 Based on observation, interview and record review, the facility failed to: 1) Ensure proper labeling of open dates and expiration dates of multi-dose medications in 2 of 2 medication carts and 2) Ensure proper labeling of glucose monitor strips for expiration date after opening, resulting in the opened and undated medications and inaccurate blood glucose monitoring. Findings include: Observation and interview on 03/25/25 at 09:28 AM with Registered Nurse (RN) D of the 200/400 medication cart revealed that she was a unit manager and staff education director, but was working the 200/300 hallway medication cart because of a staff nurse call-in. RN D unlocked the medication cart to review with the state surveyor: Resident #41's had Lantus insulin pen open date with no expiration date, and Novolog insulin pen with open date, with no expiration date. Resident #28 had Humulin 70/30 insulin pen with open date and no expiration date. Novolin 70/30 insulin pen with an open date with no expiration date. Resident #17 had Lantus insulin 100unit/ml bottle with an open date that was unreadable smudged and there was no expiration date. The bottle was not in a box with pharmacy label. Resident #4 had Aspart 70/30 insulin pen was used with no open date and with No expiration date noted. RN D reviewed all medications for proper labeling and open and expiration dates and found none on the insulin pen. Resident #35 had: Latanoprost 0.005% eye drops multi-dose bottle with no open date, and no expiration date. Resident #27 had Polymyxin/trimethoprim 0.1% (antibiotic) opened with on open date and no expiration date. Observation of the medication cart stock glucose blood sugar sticks container was opened with sticks missing with no date opened or when expected to expire. Resident #32 had (Breo) Fluticasone/vilanterol 100/25 mcg dated 2/28/25 and 3/8/2025. Resident #32 had Incruse Ellipta dated 3/8/2025 opened and used with no expiration date. Resident #49 had Advair diskus Fluticasone/Salmeterol dated 2/14/2025 with no expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with RN D reviewed all the medication containers for open dates and expiration dates. Record review of the clear medication cart overlay revealed a medication list of insulins with expiration recommendations for dating opened insulin pen and other medications. Record review of the 'Medications with Shortened Expiration Dates' form located under a clear protectant sheet on the top of the medication cart revealed: Once these products are opened, they must be used within a specific timeframe to avoid reduced stability and sterility and potentially, reduced efficacy. These medications should be labeled in such a way that the Beyond Use Date is securely attached to a part of the package and will not be discarded . Aspart, Humalog, and Humulin insulin pens were stable, in use at room temperature for 10 days. Lantus insulin bottle/pen were stable, in use at room temperature for 28 days. Glucose test strips were noted to be good for 3-6 months after opening. Record review of the facility 'Medication Administration' policy 5.3.9 injectable medications dated 6/21/20217 revealed multi-dose vials: a.) After initial use are to be labeled with the date opened and initials of healthcare professional. Open vials are to be discarded within twenty-eight (28) days . Record review of the facility 'Medication Administration' policy 5.3.9A Insulin Administration dated 6/21/20217 revealed insulin is a high-risk drug and warrants additional precautions for the safe and effective administration . (7.) Check the expiration date prior to administration to ensure it is within the usage date. Expired insulin should be immediately discarded. Vials and pens without an open date recorded should be discarded. Observation and interview on 03/25/25 at 09:48 AM with Registered Nurse (RN) P of the 100/400 hallways medication cart. RN P stated that she was working the 100/400 hallways as the floor nurse passing medications revealed: On 03/25/25 at 09:58 AM that Resident #45 had Albuterol sulfate Nebulizer inhalation ampules, with the foil packet opened with missing ampules with no date when opened. Resident #45 had Breyna (Symbicort inhaler) inhalation inhaler 160mcq/4.5 mcg had an open date, with no expiration date, and an Incruse Ellipta 62.5mcg with open date of 3/25/25 with no expiration date noted. RN P stated that she did not date the inhaler. Resident #164 who was Out to hospital had Albuterol sulfate nebulizer ampules with opened foil packet with 2 ampules loose in the box with no dates, and a Trelegy Ellipta inhaler 200mcg with an open date, but no expiration date noted. RN P had no idea about an expiration date for the medications. Resident #5 had Fluticasone Propionate inhaler 55mcg/14 mcg opened and used with no open date and No expiration date. Resident #13 had Fluticasone vilanterol Ellipta 200mcg/25mcg opened and used with no expiration date. Resident #12 had Trelegy Ellipta 100mcg opened and used with no expiration date. Resident #10 had Ipratropium/Albuterol nebulizer ampules with opened foil packet with no open date and loose ampules out of the foil packet lying in the box. (continued on next page)

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	235515	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Manor Healthcare Center	408 N Fifth Ave Tawas City, MI 48763

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #14 had Fluticasone Vilanterol Ellipta opened and used with no open date and No expiration date. Registered Nurse (RN) P reviewed all containers for open and expiration dates as surveyor requested. In an interview on 03/25/25 at 11:30 AM with Registered Nurse D came to the state surveyor to report that the blood sugar test strips are good for 6 months after opening per the medication shortened expiration sheets. RN D stated that she did throw out the other strips after the surveyor brought it to her attention. Record review of the facility pharmacy 'Medications with Shortened Expiration Dates' list dated 2024, revealed 4 sheets. The medication shortened list identified: Insulins- Aspart pen, Humalog mix pen and Humulin 70/30 pen had stability in use at room temperature was good for only 10 days. Lantus pen/bottle insulin had stability in use at room temperature was good for only 28 days. Albuterol nebulizer solution should be stored in foil pouch and was good for only 7 days once removed from pack. Breo or Incruse Ellipta expiration 6 weeks after removal from foil tray packaging. Latanoprost eye drops once opened may be stored at room temperature for up to 6 weeks. Record review of the facility 'Medication Disposal and Returns' policy 6.2 Dating and Discarding of Multidose Parenteral Vials' dated 6/17/2017 revealed nursing staff will date multidose vials and discard opened vials as outlined to decrease the risk of contamination and bacterial or fungal growth from multidose vials. (2.) Nursing staff is responsible for inspecting medications and their expiration date on a regular basis. Expired drugs should be discarded per policy and procedure .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22347 Based on observation, interview and record review, the facility failed to 1) Maintain food kitchen equipment in a sanitary and good working condition, and 2) Date prepared foods with made date and use-by date, resulting in an increased likelihood for food borne illness with hospitalization , and cross contamination affecting 57 residents who consumed oral nutrition from the facility kitchen of a total census of 57 residents. Findings Include: Review of the Public Health Service 2009 Food Code, adopted by the Michigan Food Law, effective October 1, 2012, Chapter 4-501.14 directs that equipment cleaning frequency is to be throughout the day at frequency necessary to prevent recontamination of equipment and utensils. On 3/25/25 at 9:50 a.m., during the tour of the kitchen accompanied by Dietary Manager G the following concerns were observed: -At 9:51 a.m., observation of the food processor that was cleaned and ready for use was found to have a thin layer of dark brown dried on food particles near the blade. -At 10:00 a.m., there was 1 clean silver metal pan (1/3rd size) found with dried on food particles inside. -At 10:01 a.m., a clean and ready for use sliver metal pan stacked inside another clean pan was found to have water inside. -At 10:05 a.m., on the far right side spigot of the coffee pot was found dark colored sticky substance (a build-up of coffee substance). Review of the facility Weekly Cleaning Assignment (un-dated), revealed all kitchen jobs including the proper cleaning of kitchen equipment was broken down into specific day's of the week and assigned to staff to clean. -At 10:08 a.m., the refrigerator fan covers (x 2) were observed to have an excessive amount of dust that was blowing directly on bread sticks that were sitting on the top shelf. The bread sticks had a sheet of parchment paper on top of them, however the fans were blowing the paper up on the sides. -At 10:11 a.m., in the freezer was found open and partly used bags of blue berries and rolls with no use-by dates on them. During an interview done on 3/27/25 at approximately 12:55 p.m., Dietary Aide M stated We put a use-by date on things open, usually it's about 3 days. Review of the facility Food Purchasing and Storage policy dated 12/10/2024, revealed all opened food items required dating of made by, opened, and use-by dates.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37668 Based on observation, interview and record review, the facility failed to implement and operationalize an infection control program including ensuring safe and sanitary conditions in the beauty parlor, comprehensive outcome surveillance, evaluation and analysis of data for potential trends, and identification and monitoring of potential infections for all 57 residents residing in the facility. Findings include: An interview and review of facility Infection Control (IC) data was completed with IC Registered Nurse (RN) C on 3/27/25 at 2:09 PM. Upon request to review IC data for February 2025, RN C provided a written line listing tool, a typed line listing Surveillance Monthly Report, a mapping tool, and a summary form. When queried why there were both written and typed line listing forms, RN C revealed the written form is not an official tracking tool but stated they use it to make notes regarding infections when not in their office. RN C stated they enter the appropriate information into the system and the computer program generates the official typed Infection Surveillance Monthly Report form. Review of both the typed and handwritten forms revealed each resident listed on the form had received an antimicrobial treatment for infection. When asked how they identify and track residents who have potential infections to prevent spread, RN C revealed they track residents who are receiving treatment for infection. RN C was asked how they are able to quickly identify and prevent the potential spread of infection if they do not have a system in place to track residents who have signs and symptoms of potential infection, RN C verbalized understanding and indicated they were unaware they needed to have a system for monitoring and identifying potential signs/symptoms of infection and/or infections which do not receive antimicrobial treatment. When queried if antifungal medication are included on their surveillance tracking documentation, RN C revealed the primary antifungal treatments in the facility are topical. When queried if topical antifungal medications are used to treat fungal skin infections, RN C confirmed they are. When queried if fungal skin infections can be contagious, RN C verbalized they can be. RN C was then asked why topical skin infections are not included on the official typed IC line listing surveillance and revealed they had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Summary form for February 2025 revealed no documentation of analysis for infection trends. Review of outcome surveillance data including the Infection Surveillance Monthly Report revealed the facility had a total of 13 infections which received antibiotic treatment during the month. Of the 13 infections, five were listed as pneumonia on the Infection Surveillance Monthly Report. The The Infection Summary detailed there were three Residents with pneumonia on the 100 hall and one Resident on the 200 hall. When queried why the summary only included four residents with pneumonia when the line listing detailed five, RN C revealed they must have made an error. When asked, RN C revealed three of the five residents with pneumonia were classified as facility acquired. When queried if they identified any trends in the pneumonia diagnoses, RN C stated, (Resident #32-200 hall) had aspiration pneumonia. When queried regarding the four other residents with pneumonia (#28, 211, 47, and 212) including dates of symptom onset, common caregivers, and areas/time outside of their room, RN C revealed they had not considered nor identified any potential trends previously but were able to see potential trends now. The outcome surveillance data for February 2025 further revealed the facility had four Urinary Tract Infections (UTI's), two on the 100 hall that were present on admission and two on the 400 hall that were facility acquired. When queried regarding the organisms causing the UTI's and if any trends were identified, RN C verbalized no trends were identified. Review of Culture and Sensitivity documentation for the residents listed as having UTI's revealed one resident was admitted with a UTI caused by Klebsiella Oxytoca (gram negative bacterium frequently associated with pneumonia infections) on 1/29/25 and another resident with a UTI had an infection onset date of 2/5/25 that was also caused Klebsiella Oxytoca. When asked if they considered and/or identified a potential trend, RN C stated, I do now. When queried what process surveillance was completed for the month, RN C revealed they did not know what process surveillance meant. RN C was then asked if they completed any IC audits and provided facility wide audit forms. When asked if any education was completed specific to potential IC concerns identified during process or outcome surveillance, RN C revealed no specific IC education was provided. When queried if they had previously identified an increase in infection and/or concern and completed education related to that incident, RN C revealed they had an increase in UTI's the prior year and education was completed by the previous education/staffing nurse. RN C did not have the education provided for review. Review of facility policy/procedure entitled, Infection Prevention Program Overview (Revised: 2/28/25) revealed, Policy: The infection prevention and control program (IPCP) must include, at a minimum, the following elements . investigates, identified, presents, reports and controls infection and communicable disease for all residents Infection Preventionist (IP) . serves as the coordinator of an Infection Control program . Responsibilities may include: Collecting, analyzing, and providing infection data and trends to nursing staff and healthcare practitioners. Consulting on infection risk assessment, prevention, and control strategies. Providing education and training; Implementing evidence based infection control practices including those mandated by regulatory and licensing agencies . 22347 Observation was made of the resident's beauty parlor on 3/26/25 at 3:35 p.m., during the environmental tour accompanied by Director of Maintenance and Housekeeping H, the Administrator and Infection Control Nurse C. The resident's beauty parlor was found to have the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At , in several (x 4 drawers) of the black plastic equipment drawers was observed an excessive amount of hair, dust, and pieces of paper. The drawers looked like they had not been cleaned for an extended amount of time. -In 2 of the black plastic drawers, a pile of used curlers was found with a lot of hair in them. -x 2 electric razors were found in the top left side drawer with skin and hair on both of the blades. -A black bin had small curlers sitting in it with hair, dust and pieces of paper in the bottom of the bin. During an interview done 3/27/25 at 1:12 p.m., Director of Maintenance and Housekeeper stated, They (housekeeping staff in the facility beauty parlor) are to clean the countertop sink and floor, they do not do the equipment. They are supposed to clean that (community equipment, including razors and curlers) that after every use. During an interview done on 3/26/25 at 3:30 PM, the Infection Control Nurse C was taken to the room upon her request and shown the condition of the beauty parlor. Infection Control Nurse C stated It's discussing, gross. I do come in here every once on a while. Review of the Infection Control environmental walk-through dated 2/25, revealed 3 thing to observe in the beauty parlor (hygiene, equipment disinfected and chemicals stored properly).