STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235523	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Nursing Center	22401 Foster Winter Dr Southfield, MI 48075

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34208 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than five percent for two residents (R#'s 112 and 118) of three residents reviewed for medication administration, resulting in a medication error rate of 6.45%. Findings include: A review of a facility provided policy titled, Safe Medication Administration Practices revised 7/2021 was conducted and read, .15. A nurse is responsible for for verification that the correct medication is being administered at the proper time, prescribed dose, correct route, and correct patient . On 4/29/24 at 8:52 AM, Nurse 'D' was observed preparing medications for administration to R118. Nurse 'D' prepared multiple medications including cetrizine 10 mg (milligrams) (Zyrtec, allergy medication). Nurse 'D' proceeded to R118's room and administered the medications. After exiting the room, Nurse 'D' signed the medications out as given in the electronic medication administration record. At the conclusion, Nurse 'D' was asked if all due medications for that time had been administered and they indicated they had. 4/29/24 at 12:15 PM, R118's physician's orders were compared to the medications observed for administration by Nurse 'D at 8:52 AM. During the reconciliation, it was noted R118 did not have an order for cetrizine 10 mg, rather they had an order for loratidine 10 mg (Claritin, a similar allergy medication). On 4/29/24 at 12:33 PM, R118's orders and medications in their stock were reviewed with Nurse 'D'. They confirmed R118 did not have an order for cetrizine, but did have an order for loratidine, however; no loratidine was contained within R118's medication stock. On 5/1/24 at 8:25 AM, Nurse 'D' was observed preparing medications for administration to R112. Nurse 'D' prepared multiple medications, proceeded to R112's room and administered them. Upon exiting the room, Nurse 'D' signed the medications out as given and was asked if all due medications had been administered at that time. Nurse 'D' confirmed they had been. On 5/1/24 at 9:02 AM, R112's physician's orders were reconciled against the medications observed to be administered to R112. It was noted R112 had an order for Miralax (laxative) 17g (grams) scheduled for administration at 9:00 AM, however; the Miralax was not observed to be given at the time of the other medications. (continued on next page)

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at approximately 10:30 AM, an interview was conducted with the facility's Director of Nursing regarding the medication concerns identified. They indicated medications should be administered per the, Five Rights, right resident, right medication, right dose, right route, and right time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 4/29/24 between 9:40 AM-10:00 AM, during an initial tour of the kitchen with Registered Dietician A (RD A), the following items were observed: 1. The vent shielding was observed to contain grease and cobwebs webs covering the shield. The top and the side of the oven were observed to contain dried [NAME] splatter. The dried rack of stacked pans were observed to still contain water droplets inside the pans. At 9:50 a.m., the dish machine was observed to have finished washing the morning dishes and a test of the rinse cycle on the dishwater machine got to 111 degrees. A second try on the dish machine was conducted and the temperature reached 115. The dish machine indicated that the temperature should reach greater than 120. RD A indicated that the dish machine had not been set to the correct setting to reach the appropriate temperature that morning by a new staff member. At that time, the dish machine temperature testing logs were reviewed and revealed no temperature had been taken prior to the breakfast dishes being cleaned/rinsed. RD A was queried if the kitchen staff should be taking the temperature prior to finishing the dishes and they indicated that they should and should be logging the temperature on the dish machine log. 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. 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. On 5/1/24 a facility document titled Sanitation Program was reviewed and revealed the following: POLICY: The Food and Nutrition Services Department maintains a sanitation program. PURPOSE: To maintain a clean, safe and effective environment of care, and to prevent the transmission of disease-carrying organisms . A second document titled Infection Control was reviewed and revealed the following: PURPOSE: To prevent and control contamination and the spread of infection within the department and the Hospital .All equipment shall be thoroughly cleaned after each use. (See Nutritional Services Procedure Manual.) . Dishwasher: Shall be maintained and operated per manufacturer's directions. Record temperature at each meal and sanitizer solution at each meal and compare to the test strip package scale .

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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** 34208 Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices with regards to transmission-based precautions (TBP), linen storage, and disposal of used personal protective equipment (PPE). This deficient practice had the potential to affect all 20 residents in the facility. Findings include: On 4/29/24 at 8:46 AM, Room #'s 321, 323, 327, and 332 were observed to have over the door caddys containing personal protective equipment such as isolation gowns, gloves, and masks stored in them. It was observed there was no signage to indicate the type of TBP (contact, droplet, airborne, etc.) On 4/29/24 at 9:10 AM, 4/30/24 at 9:33 AM, 12:10 PM, and 3:07 PM, and 5/1/24 at 9:00 AM, a linen cart in the hallway was observed to have two boxes of gloves, three rolls of trash bags, and various gowns and linens stored on it's top. On 4/29/24 at 10:30 AM, 4/30/24 at 9:33 AM, 12:03 PM, a small garbage can outside of room [ROOM NUMBER] was observed to contain used PPE (isolation gowns, gloves, and masks). On 4/29/24 at 1:00 PM, room [ROOM NUMBER] was observed to have a caddy over the door containing PPE supplies. Signage to identify the type of TBP was not observed at that time. On 4/29/24 at approximately 2:14 p.m., Housekeeper C was observed donning PPE and going into a room noted to be on TBP to clean. Housekeeper C was then observed coming out of the room and into the clean hallway without doffing the PPE from the contaminated room. On 4/30/24 at approximately 8:27 AM and 8:39 AM, the clean linen cart on the resident hallway was observed to have the protective cover flipped up, exposing the clean linens to potential contaminants. On 5/1/24 at approximately 9:30 AM, a review of orders for residents residing in room #'s 321, 323, 327, 332, and 335 was conducted. It was noted the orders in the records did include orders for TBP, however; none of the orders documented the type of TBP. On 5/1/24 at 9:42 AM, an interview was conducted with Infection Preventionist 'B' about infection controls concerns identified. During the interview they explained that TBP rooms should have signage that designated they type of TBP, all PPE should be doffed and discarded in the TBP room, and linen carts should be covered with nothing stored on the top of them. A review of a facility provided policy titled, isolation and Transmission-Based Precautionsrevised 4/2024 was conducted and read, .Attending or covering physician will write the order for placement into transmission-based precautions .Documentation in the electronic medical record should include the type of precautions/isolation .An appropriate sign must be posted on the door to the patient/resident room; specific condition or diagnosis is not given . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a second facility provided policy titled, General Infection Prevention and Control revised 1/2024 was reviewed and read, .V. Storage & Separation of Clean versus Dirty .A. Cleaned patient care supplies should be transported and stored in a designated clean area and in a manner which minimizes recontamination. B. Clean equipment must be differentiated from soiled equipment. This may include, but is not limited, to the following options: 1. Equipment placed in a designated clean space. 2. Protective covering or bag placed over clean items .VI. Linen .C. Linen is covered at all times prior to use and is stored on a shelf . 38271