STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	1400 Poplar Street Hancock, MI 49930

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 - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 1234673Based on interviews and record review, the facility failed to develop and implement a person-centered plan of care for one Resident (#44) of 12 residents reviewed for comprehensive care plans, resulting in the potential for aspiration and impaired physical, mental, and psychosocial well-being.Findings include:Resident #44 (R44)Review of the admission Record Face Sheet revealed R44 was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses including unsteadiness on feet and dysphasia (difficulty swallowing). Review of the Minimum Data Set (MDS) dated [DATE] revealed R44 had a brief interview for mental status (BIMS) score of 00 out of 15 which indicated he was severely cognitively impaired. Review of R44's Care Plan revealed, there was no person-centered care plan put into place for the focus area of having a feeding tube. During an interview on 7/24/2025 at 8:38 AM, Licensed Practical Nurse (LPN) J reported they did not recall much of R44 because the resident had been discharged for quite some time. LPN J reported they did recall R44 had a few hospitalizations for aspiration pneumonia and did have a feeding tube because R44 would refuse to eat and drink, and had difficulty swallowing. During an interview on 7/24/25 at 12:30 P.M., the Director of Nursing (DON) reported R44 should have had a person centered care plan in place for his feeding tube as a focus area with measurable goals and proper interventions. The DON indicated any nurse can update the care plans, but typically she had been doing them. The DON reported the MDS nurse working at the facility at the time R44 was in the facility no longer worked there. The DON reported she was aware of resident care plans not being developed as they should, or implemented and revised as they should be. Review of a facility Policy with a revision date of 6/2024 revealed: Policy.The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. The initial care conference will be held within 72 hours of admission and quarterly thereafter.Policy Explanation and Compliance Guidelines:1. The baseline care plan will:a. Be developed within 48 hours of a resident's admission.b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:i. Initial goals based on admission orders.ii. Physician orders, iii. Dietary orders.iv. Therapy services.V. Social services, vi. PASARR recommendation, if applicable.1. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable.a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives.b. Interventions shall be initiated that address the resident's current needs including:i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk.ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.living.111. Any special needs such as IV therapy, dialysis, or wound care.3. A written summary of the baseline care plan shall be provided to the resident and representatives in a language that the resident/representative can understand. The summary shall include, at a minimum, the following:a. The initial goals of the resident.b. A summary of the resident's medications and dietary instructions.c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.3. If the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable.4. The comprehensive care plan is developed from the RAI scheduled and is reviewed and revised by the IDT as necessary.

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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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update and revise care plan interventions for 1 Resident (#7) of 12 residents reviewed for care plan revision, resulting in the potential for unmet resident care needs, increased falls, unsafe resident environment, and resident injury. Findings include:Resident #7 (R7)Review of the admission Record Face Sheet revealed R7 was admitted to the facility on [DATE] with diagnoses including repeated falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed R7 had a brief interview for mental status (BIMS) score of 13 out of 15, indicating cognition was intact. In an interview on 7/24/2025 at 8:51 AM, R7 reported he had fallen out of bed quite a few times trying to reach for things, or self-transfer. R7 reported he has not been injured but does have pain in his right elbow from a car accident he was in many years ago. Review of R7's Care Plan revealed: Focus At risk for falls aeb (as evidence by) impaired gait and mobility r/t (related to) s/p (status post) CVA (cerebrovascular accident/stroke), muscle weakness, seizures, encephalopathy (disorder or disease of the brain), impaired safety awareness, fatigue, use of antipsychotic medications, and h/o falls. Recommended to have assist x1 for transfers but continues to get up without assistance or using the call light. Date Initiated: 11/05/2022 Revision on: 07/23/2024. further review of R7's care plan revealed interventions had not updated/revised to reflect his current status of recent falls. Nor did the care plan address any additional identification of possible preventative measures. During an interview on 7/24/25 at 12:30 P.M., the Director of Nursing (DON) reported R7 should have had updated/revised care plan interventions for R7's Falls care plan. The DON reported she was aware of resident care plan intervention not being revised as they should be. The DON reported there have been many changes with staff in the last few months, so it has been hard to keep on ensuring care plans reflect the resident's current status and are individualized to reflect changes. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 2: Assessments for the Resident Assessment Instrument (RAI), revealed .the resident's care plan must be reviewed after each assessment .and revised based on changing goals, preferences and needs of the resident and in response to current interventions .Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan . Review of a facility Policy with a revision date of 6/2024 revealed: Policy.The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. The initial care conference will be held within 72 hours of admission and quarterly thereafter.Policy Explanation and Compliance Guidelines:1. The baseline care plan will:a. Be developed within 48 hours of a resident's admission.b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:i. Initial goals based on admission orders.ii. Physician orders, iii. Dietary orders.iv. Therapy services.V. Social services, vi. PASARR (Preadmission screening and annual resident review) recommendation, if applicable.1. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable.a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives.b. Interventions shall be initiated that address the resident's current needs including:i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk.ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.living.111. Any special needs such as IV therapy, dialysis, or wound care.3. A written summary of the baseline care plan shall be provided to the resident and representatives in a language that the resident/representative can understand. The summary shall include, at a minimum, the following:a. The initial goals of the resident.b. A summary of the resident's medications and dietary instructions.c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.3. If the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable.4. The comprehensive care plan is developed from the RAI scheduled and is reviewed and revised by the IDT (Interdisciplinary Team) as necessary

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide Activities of Daily Living (ADL) care i.e. bathing and grooming services for one Resident (R5) of two residents reviewed for ADL care which resulted in unmet care needs.Findings include:Resident #5 (R5)Review of the Minimum Data Set (MDS) assessment for R5, dated 5/13/25, revealed admission to the facility on 2/13/25. R5 scored 13 of 15 on the Brief Interview for Mental Status (BIMS) assessment, reflective of intact cognition. Section GG revealed R5 requires partial to moderate assistance for showers/bathing and set up or clean-up assistance for shaving.During an observation and interview on 7/22/25 at 1:40 p.m., R5 was sitting in a recliner in his room. R5 had long facial whiskers and disheveled hair. R5 stated, I haven't had a shower in two weeks, and no one will help me.I can't do it myself and would like to be shaved.My facial hair itches me.I would like to have a haircut too.On 7/23/25 at 9:30 a.m., R5 was observed sitting in his recliner in his room, still unshaved. On 7/23/25 at 9:30 a.m., during a follow-up interview, R5 reported he was not offered a shower this morning. During an interview on 7/24/25 at 8:40 a.m., the Director of Nursing (DON) reported residents receive showers weekly.During an interview on 7/24/25 at 8:42 a.m., Certified Nurse Aide (CNA) F reported residents receive showers weekly and shaving is offered weekly which occurs on the day the resident receives a shower.Review of the CNA shower log revealed R5 had not received a shower since 7/9/25 and had not refused a shower.Review of R5's care plan revealed they required assistance of one person when receiving a shower.During an interview on 7/24/25 at 3:15 p.m., the Nursing Home Administrator (NHA) acknowledged the residents should receive a shower weekly and residents should be shaved weekly if the residents requested to be shaved.Review of facility policy titled Activities of Daily Living (ADL) date implemented 2/25/24, read in part .Care and services will be provided for the following activities of daily living bathing, dressing, grooming.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oxygen services including humidification and routinely changing oxygen tubing for one Resident (#11) of two residents reviewed for oxygen services. This deficient practice resulted in discomfort and unmet care needs.Findings include:Resident #11 (R11)Review of Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 2/23/22, with active diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and respiratory failure. R11 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition.During an observation on 7/22/25 at 1:20 p.m., R11 received oxygen via nasal cannula with an empty bottle of humidification solution attached to the oxygen concentrator and the label on the oxygen tubing was dated 6/30/25. During an interview at the time of this observation, R11 reported that her nose was very sore and dry from the oxygen.During an observation on 7/23/25 at 10:12 a.m., the oxygen concentrator for R11 was noted to have an empty bottle of humification solution attached to the oxygen concentrator and the label on the oxygen tubing was dated 6/30/25.During an interview on 7/24/25 at 8:34 a.m., Licensed Practical Nurse (LPN) G reported the tubing is changed weekly on night shift and the bottle of solution on the oxygen concentrator lasts 3 days.During an interview on 7/24/25 at 8:37 a.m., the Director of Nursing (DON) reported the oxygen tubing is changed weekly on night shift and that the humidification solution is monitored every night.Review of Doctors' order revealed oxygen with a start date of 3/13/25 for R11 to receive oxygen 4 liters by nasal cannula to maintain sats (saturation) greater than or equal to 88%.Review of facility policy titled Oxygen Administration and Concentrator Policy, last reviewed/revised 6/23, read in part .nasal cannula.requires humidification for flow rates of.4 liters. Review of facility policy titled Oxygen Concentrator, date implemented 1/1/21, read in part .fill the humidifier container to the correct level with distilled water and attach to the concentrator.changed oxygen tubing and mask/cannula weekly or as needed.change humidifier bottle when empty.During an interview on 7/24/25 at 3:15 p.m., the Nursing Home Administrator (NHA) acknowledged the oxygen concentrator for R11 was always supposed to have humidification solution present and the oxygen tubing is supposed to be changed weekly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication administration error rate less than 5% in two Residents (#2 & #7) of three residents reviewed for medication administration, resulting in 2 medication errors in 26 opportunities for error and a 7.69% medication error rate.Findings include:Resident #2 (R2)On 7/24/25 at 9:01 a.m., Registered Nurse (RN) J was observed preparing an insulin pen for R2. RN J primed the pen holding it horizontally, with he needle cover on the pen. RN J did not observe the pen to ensure that insulin was primed into the pen needle, nor did he reprime to ensure it was done correctly. Review of the INSTRUCTIONS FOR USE, Insulin Lispro KwikPen, copyright 2023, retrieved from pi.[NAME].com/insulin-lispro-kwikpen-us-ifu-pdf on 7/24/25 at 9:51 a.m. revealed the following, in part: . Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle and repeat priming steps 6 to 8 .Resident #25 (R25)On 7/24/25 at 8:46 a.m., RN J was observed leaving a prepared dose of miralax on R25's over bed table and left the room. When asked if R25 was able to self-administer medications, RN J said he could not tell this surveyor and reported that he could go back and watch her take the miralax.During an interview on 7/24/25 at 8:48 a.m., the Director of Nursing (DON) stated if the resident is in their room alone, the nurse should stay with the resident until the resident consumes the medication. Review of facility policy titled Preparation and General Guidelines IIA2: Medication Administration-General Guidelines, last revised 1/18, read in part .Medications are administered at the time they are prepared.the resident is always observed after medication administration to ensure that the dose was completely ingested.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ a certified dietary manager or certified food service manager to manage the food service department.Findings include:During an interview on 7/22/25 at 4:24 p.m., the Business office Manager/Human Resources Manager E reported the Dietary Manager was not certified.During a follow-up interview on 7/24/25 at 12:55 p.m., the Business Office Manager/Human Resources Manager E reported the Dietary Manager was promoted to Dietary Manager on 11/20/23 but did not become certified.Review of the facility Job description for the Dietary Manager revealed under education and training, the Dietary Manager was required to be certified.During an interview on 7/24/25 at 3:15 p.m., the Nursing Home Administrator (NHA) acknowledged the Dietary Manager did not meet the qualifications of the job.The FDA Food Code identifies an acceptable level of education for a person in charge of a food service operation as: 2-102.11 Demonstration.Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by:(A) Complying with this Code by having no violations of PRIORITY ITEMS during the current inspection; Pf(B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure staff had the appropriate competencies and skills to carry out functions of the food and nutrition services. This deficient practice had the potential to affect all 38 facility residents.Findings include:During an observation on 7/22/25 at 11:28 a.m. , the resident refrigerator had two small containers of food with a resident's name on a label but no date as to when it was brought to the facility or a use by date. There were also four containers of apple sauce with a use by date of 7/21/25 located in the resident refrigerator.During an interview on 7/22/25 at 11:34 a.m., Dietary Staff D reported she had already looked in the resident refrigerator and all the dates and food in the resident refrigerator were checked and the items in the refrigerator were labeled.During an interview on 7/22/25 at 11:38 a.m., Dietary Staff B reported she was unsure what temperature the resident's food had to be prior to serving the residents. During an observation on 7/23/25 at 8:53 a.m., there were two opened packages of deli meat on a small tray in the resident refrigerator. The tray was wet from the deli meat. Directly under the tray of meat on the shelf was an opened box of apples. During an interview on 7/23/25 at 8:59 a.m., Dietary Staff C reported the apples shouldn't be under the deli meat because the apples could be contaminated. However, they were not going to throw them away because they stated, that is above my pay grade.During an interview on 7/23/25 at 12:30 p.m., when queried about when the dietary staff check the dates on the food items in the freezer, refrigerator, dry storage, and in the main kitchen. Dietary Staff B stated, We don't really look at the dates and shrugged their shoulders. During an interview on 7/24/25 at 3:15 p.m., the Nursing Home Administrator (NHA) acknowledged concerns about the dating of food items and the competency of the dietary staff.

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional stands for food service safety as evidenced by:- Failing to ensure labeling of food- Failing to ensure expired food was discarded- Failing to prevent possible contamination of fresh produce- Failing to prevent possible cross contamination from kitchen appliances- Failing to ensure the ice machine drainage pipe has a two-inch air gap to the floor drainThis deficient practice had the potential to result in food borne illness among any or all 38 residents in the facility who receive meals.Findings include:During an observation on 7/22/25 at 11:10 a.m., the walk-in refrigerator contained two unsealed, undated packages of deli meat stored directly over an uncovered open box of fresh apples.During an interview on 7/22/25 at 11:10 a.m., Dietary Staff B acknowledged the fresh apples would be considered contaminated due to the deli meat possibly leaking on the apples and then stated, I didn't do it.During an observation on 7/23/25 at 8:53 a.m., the walk-in refrigerator contained packages of deli meat stored directly over an uncovered open box of fresh apples. During an interview on 7/23/25 at 8:59 a.m., Dietary [NAME] C reported the apples shouldn't be under the deli meat because the apples could be contaminated. However, he wasn't going to throw them away because he stated, that is above my pay grade.Review of facility policy titled Food Storage, date reviewed/revised 1/24, read in part .meats shall we stored on shelves below fruits. so that meat juices to not potentially drip onto these foods.According to the 2022 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,(b) Cooked READY-TO-EAT FOOD. During an observation on 7/22/25 at approximately 11:15 a.m., the log books revealed:1. Food temps were not completed for the evening meal on 7/21/25 or the breakfast meal on 7/22/25.2. Dishwasher temperatures were not completed in the evening of 7/21/25 or the morning of 7/22/25.During an observation on 7/22/25 at 11:18 a.m., the dry storage area contained:1. Noodles dated as opened on 5/19/25 and a use by date of 6/19/25.2. A second opened bag of noodles with no open or use by date. 3. A bag of instant pudding with an expiration date of 3/20/25.4. Fruit drink mix that was out of the original box and no label of a use by or expiration date on the drink mix.Review of facility policy titled Food Storage, last reviewed/revised 1/24, read in part .food items in dry storage not in the original delivery box will be dated upon receiving with month, day and year. During an observation on 7/22/25 at 11:28 a.m., the resident refrigerator had two small containers of food with a resident's name on a label but no date as to when it was brought to the facility or a use by date. There were also four containers of apple sauce with a use by date of 7/21/25 located in the resident refrigerator.During an interview on 7/22/25 at 11:34 a.m., Dietary Staff D reported she had already looked in the resident refrigerator and all the dates and food in the resident refrigerator were checked and the items in the refrigerator were labeled.Review of facility policy titled Use and Storage of Food Brought in by Family or Visitors, last reviewed/revised 1/21, read in part .All food items that are already prepared by the family or visitor.must be labeled with resident name and date.During an interview on 7/22/25 at 11:38 a.m., When taking temperatures of the food, Dietary Staff B reported she was unsure what temperature the resident's food had to be prior to serving the residents. During an observation on 7/22/25 at 11:47 a.m., the following was noted:1. A bin of flour with an open date of 6/7/25 and a use by date of 7/7/25.2. A bag of walnuts that was opened with an open date of 5/29/25 and a use by date of 6/29/25. 3. A bottle of vanilla that was opened with an open date of 3/23/25 and a use by date of 5/23/25.4. A large bag of potato chips that was opened with no open date or use by date.5. A bag of brown sugar that was opened with no open date or use by date.6. A bag of marshmallows that were opened with no open date or use by date.During an observation on 7/23/25 at 8:53 a.m., the following was noted:1. A tray with 9 containers filled with pureed cookies that were not labeled or dated in the refrigerator. 2. A container of mozzarella cheese with an open date of 7/15/25 and a use by date of 7/21/25.During an observation on 7/23/25 at 12:24 a.m., the mounted can opener was observed to contain black and brown slimy debris that was attached to the underside of the can opener near the blade. The can opener post was sticky, slimy, and black. The can opener holder had black and brown debris that clung to the sides of the holder.During an interview on 7/23/24 at 12:28 p.m., Dietary Staff C reported that the can opener is wiped down every day. During an interview on 7/23/24 at 12:30 p.m., Dietary Staff B looked at the can opener

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review the governing body failed to hire a licensed Nursing Home Administrator (NHA) to oversee the day-to-day operations of the facility and ensure the federal regulations are being followed.Findings include:During an interview on 7/22/25 at 11:05 a.m., the Director of Nursing (DON) reported that there was not a Nursing Home Administrator in the building, and she was taking care of everything in the facility.During an interview on 7/22/25 at 12:46 a.m., the Business Office Manager/Human Resource Manger E reported that the Nursing Home Administrator has been out of the facility since May but there is a new one starting on 7/23/25.During an observation on 7/22/25 at approximately 12:48 p.m., this surveyor noted that the Business Office Manager/Human Resource Manager E removed a NHA license that was posted in the hallway from the previous administrator.During a phone interview on 7/22/25 at 2:57 p.m., the previous Nursing Home Administrator reported that she had not been in the facility since May and was surprised that her license would still be posted within the facility. Review of the Employee list provided by the facility revealed that the Current Nursing Home Administrator was hired on 7/22/25.Review of the Federal Nursing Home Reform Act of 1987 revealed that nursing homes are required to have a licensed nursing home administrator to oversee the facility's day-to-day operations and ensure resident care. This requirement is based on both federal and state regulations.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident representative understood the purpose of binding arbitration agreements (an out of court alternate form of dispute resolution) for two Residents (Resident #8 and Resident #31) of three residents reviewed for arbitration.Findings include:Resident #8 (R8)Review of R8's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 5/12/22, with active diagnoses that included: Alzheimer's Disease, Non-Alzheimer's dementia, and anxiety disorder.During an interview on 7/25/25 at 9:10 a.m., Social Worker A reported R8 signed the arbitration agreement on 1/9/25. Social Worker A reported R8 had a responsible party (an individual designated to oversee various aspects of a resident's care and well-being) put in place which began on 1/17/25. Social Worker A acknowledged she did not review the arbitration agreement with the responsible party.Resident #31 (R31)Review of R31's MDS assessment dated [DATE], revealed admission to the facility on 9/13/23, with active diagnoses that included: non-Alzheimer's dementia, cerebrovascular accident (when blood flow to a part of your brain is stopped) and seizure disorder or epilepsy.During an interview on 7/25/25 at 9:10 a.m., Social Worker A reported R31 signed the arbitration agreement on 3/26/25. Social Worker A reported R31 had a responsible party which began on 4/22/25. Social Worker A acknowledged she did not review the arbitration agreement with the responsible party.Review of facility policy titled Binding Arbitration Agreements last reviewed/revised 11/1/22 read in part, .the facility shall explicitly inform the resident or his or her representative of his or her right not to sign the agreement.explain to the resident and his or her representative in a form and manner that he or she understands.ensure the resident or his or her representative acknowledges that he or she understands the agreement.explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to develop, implement, and maintain an effective, and comprehensive Quality Assurance Performance Improvement (QAPI) program that addresses the full range of services the facility provides. This deficient practice resulted in the potential for quality-of-care concerns for all 38 residents in the facility.Findings include:During an interview on 7/25/25 at 8:38 a.m., the Director of Nursing (DON) reported, during the May 2025 QAPI meeting the team members did not go over anything as they were waiting for the whole team to be present.the Nursing Home Administrator (NHA) was not present and the Infection Preventionist (IP) was not present.During an interview on 7/25/25 at 9:43 a.m., the NHA reported the DON supervised the QAPI program.During an interview on 7/25/25 at 9:49 a.m., the DON reported the facility is not working on any Performance Improvement Projects (PIPS).we are not doing any data collection to assess for any problems within the facility.there are no action plans or anything the facility has been working on for QAPI.there is no feedback, analysis or tracking for the QAPI program. The DON then stated, I really don't have anything. I don't understand what the QAPI program is supposed to do. Review of a policy titled Quality Assurance and Performance Improvement, last reviewed/revised 3/24, read in part .It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to establish priorities for its improvement activities, develop and implement action plans, and review or analyze data collected under the Quality Assurance Performance Improvement (QAPI) program. This deficient practice resulted in the potential for quality-of-care concerns for all 38 residents in the facility.Findings include:During an interview on 7/25/25 at 9:49 a.m., the Director of Nursing (DON) reported the facility is not working on any Performance Improvement Projects (PIPS).we are not doing any data collection to assess for any problems within the facility.there are no action plans or anything the facility has been working on for QAPI.there is no feedback, analysis or tracking for the QAPI program. The DON then stated, I really don't have anything, I don't understand what the QAPI program is supposed to do.Review of Facility policy titled Quality Assurance and Performance Improvement, last reviewed/revised 3/24, read in part .It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee met at least once per quarter with the required committee members. This deficient practice resulted in the potential for quality-of-care concerns for all 38 residents in the facility. Findings include:A review of the facility QAPI sign-in sheets revealed the following:The QAPI meeting was held on 5/15/25: The Nursing Home Administrator (NHA) did not attend the meeting and the Infection Preventionist did not attend the meeting.The facility did not have a QAPI meeting in April of 2025 or June of 2025.During an interview on 7/25/25 at 8:38 a.m., the Director of Nursing (DON) reported that the NHA did not attend the meeting, and the facility did not have an Infection Preventionist.A review of the facility policy titled Quality Assurance and Performance Improvement last reviewed/revised 3/2024, read in part .The QA committee shall.consist.of the Director of Nursing, Medical Director or designee, three other members of the facility staff, at least one of which must be the administrator. and the infection control and prevention officer. and meet at least quarterly.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to implement and operationalize their policy for antibiotic stewardship program and failed to ensure accurate monitoring of antibiotic use resulting in the potential for inappropriate antibiotic utilization and worsening or non-improving infections for all 38 residents residing within the facility as well as the potential for antibiotic resistance.Review of the facility's Infection Prevention and Control binder revealed multiple residents who had taken antibiotics on different occasions over different months of the look back period for antibiotic tracking sheets had an N under the antibiotic tracking sheet area of was criteria followed. The criteria per facility protocol had McGeer's Criteria listed. During an interview on 7/25/25 at 1:45 PM., the Director of Nursing (DON) reported she was the Infection Control Preventionist for the facility. The DON reported that she and or the physicians do not always use McGeer's criteria or any other acceptable/accredited antibiotic criteria when prescribing antibiotics. The DON reported she will go by signs and symptoms of certain residents because of her experience in Long Term Care. The DON reported sometimes residents don't meet the criteria, but not all residents will have symptoms when they have a UTI, or another type of infection. The DON reported she did not have the required Infection Control Preventionist training certificate. Review of a facility Policy with a revision date of 1/2024 revealed: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Policy Explanation and Compliance Guidelines: 1. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the Antibiotic Stewardship Program: a. Infection Preventionist - coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff. b. Director of Nursing - serves as back up coordinator for antibiotic stewardship activities, provides support and oversight and ensures adequate resources for carrying out the program. c. Administrator - provides adequate resources for carrying out the program and ensures review of antibiotic use and resistance data at QAPI meetings. 2. The Medical Director, Consultant Pharmacist, and Attending Physicians and/or Midlevel Providers support the program via active participation in developing, promoting, and implementing a facility wide system for monitoring the use of antibiotics. a. Medical Director - serves as the primary medical point of contact for the program and serves as a liaison between the facility and other medical staff members. b. Consultant Pharmacist - reviews antibiotics prescribed to residents during their medication regimen review and serves as a resource for questions related to antibiotics. c. Attending Physicians/Midlevel Providers - prescribe appropriate antibiotics in accordance with standards of practice and facility protocols. 3. Licensed nurses participate in the program through assessment of residents and following protocols as established by the program. 4. The program includes protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection and notify the physician as applicable. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses McGeer's Criteria to define infections. iv. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. v. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized. b. Monitoring antibiotic use: i. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. ii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. iii. Antibiotic use shall be measured by monthly prevalence.iv. A review of the facility's antibiogram will be performed every 18-24 months to guide development or revision of antibiotic use protocols or prescribing practices. 5. At least annually, feedback shall be provided on the facility's antibiotic use data shared with the QAPI Committee. 6. At least annually, the Medical Director shall be provided feedback on prescriber antibiotic use data. 7. Education regarding antibiotic stewardship shall be provided at least annually to nursing staff. 8. The elements of the program and associated protocols are reviewed on an annual basis as part of the facility's review of the overall infection prevention and control program. 9. Data obtained from antibiotic stewardship monitoring activities is discussed in the facility's QAPI meetings.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review the facility failed to ensure the acting Infection Control Preventionist (ICP) had the proper training and certification to ensure infection control measures were in place and being followed per federal regulation and the facility's policy, resulting in the potential for all residents residing in the facility to be at risk for serious infections and complications from different types of infections. Findings include: During an interview on 7/25/25 at 1:45 PM., the Director of Nursing (DON) reported she was the Infection Control Preventionist (ICP) for the facility. The DON reported she does not have the required Infection Control Prevention certification that she should. The DON reported the facility has been short staffed and she has been trying to keep up. The DON reported the new Nursing Home Administrator (NHA) has the required ICP certification as well as another staff member. DON reported the NHA has only been at the facility for 2 days, and the other staff member who holds the ICP certificate has been assigned as the wound nurse. DON reported she has been unable to keep up with the actual duties that are required by the ICP, as she is also the DON. Review of the facility Infection prevention & control program Routine Duties with no dated revealed: Daily Duties: Monitor the (Name Brand Electronic Medical Record [EMR]) Dashboard for any new antimicrobial orders - ensure diagnosis meets McGeer Criteria, stop date present on order, dosed per CDC (as applicable), diagnosis/indication for use on the order itself, complete the Infection Report UDA, trigger care plan for infection/antimicrobial use, and implement proper IC precautions, as applicable. Add the new infection to the IC line listing/map for tracking. Review in AM meeting and educate dept heads so they can cascade the information to their teams. Identify any staff illness and add to tracking document when they return to work. Refer to employee illness policy for when they are eligible to return to work. Be sure to document return to work dates of employees. Monitor the (Name Brand EMR) dashboard - alerts and weights/vitals tab for any change in condition or s/sx (symptoms) of infection. Order labs/contact physician/initiate change in condition if needed. Implement IC (Infection Control) precautions immediately, as applicable. Review wound assessment documentation for indication of skin/wound infection. Work with admissions team to review any new referrals for infections, colonization, or MDRO (Multi Drug Resistant Organism) status. Choose room according to required precautions. Notify staff ahead of time of admission/precautions. Ensure transmission-based precautions (isolation) placed on room door and PPE (Personal Protective Equipment) available for room if applicable. Monitor residents on antimicrobial therapy for effectiveness and for medication side effects via antibiotic time-out. If they are not showing improvement after 48-72 hours (about 3 days), contact the physician for further directions. Document applicable findings and notification in EHR (Electronic Health Record). Monitor for outbreaks - three or more cases on a unit (except for COVID-19 where 1 new case equates an outbreak) - implement outbreak procedure; notify Health Department as required. Complete/delegate IC audits per risk assessment or other identified need (ex. outbreak); be sure to provide surveillance to all areas of the facility (i.e., kitchen, laundry, storage rooms, nurse's stations, resident rooms, resident rooms, etc.). Monitor immunizations for new admissions and ensure the immunization tab is updated/consents uploaded. Verify immunization status in MCIR (state based immunization registry). Alert Housekeeping team to high-risk rooms for increased cleaning: residents with infections, residents on IV therapy, isolation rooms.Monthly Duties: Complete a monthly summary (seek trends/patterns) and map for the facility for each type of infection and overall infection rate per 1,000 resident days (calculation: [total # of in-house acquired infections / # of resident days] xIOOO = monthly infection rate). Summarize employee illnesses (all depts) and identify any correlation to resident illness (or indicate if none). Evaluate any outbreaks - ensure a separate line list is completed and write a summary/timeline of all actions taken. Verify notification of Health Department, Medical Director, Residents, Staff, Responsible Parties, QAPI (Quality Assurance Process Improvement). Summarize audits completed for the month to identify any education needed for staff or change in frequency/type of audits. Add a copy of any education/sign in log to IC binder. Complete hand hygiene audits weekly with addition of PPE audits if isolation rooms present. After the above is completed, write out a report to bring to QAPI. The Pharmacist Consultant attends QAPI quarterly and should provide a report on antibiotic ordering trends and pharmacy recommendations; this report is to be reviewed by the Medical Director. Provide PRN education to residents on antibiotic stewardship/infection control (ex. handwashing, antibiotic use, transmission-based precautions, pandemic awareness)- May attend Resident Council, if committee approves, small group and/or educate 1:1. Review vaccination status of all residents and staff. Schedule immunizations, or boosters, as indicated