STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235569	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ovid Healthcare Center	9480 E M-21 Ovid, MI 48866

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on interview and record review, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) accurately reflected the estimated cost of items and services for which the resident may be charged for two (Resident #13 and #14) of three reviewed for Beneficiary Notification. Findings include: Resident #13 (R13): Review of the medical record reflected R13 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included heart failure, chronic kidney disease and diabetes. Facility documentation reflected R13 exhausted their Medicare Part A benefit days, with a last covered day of 8/26/24, and remained in the facility. The ABN form included the cost per 15 minutes of Occupational Therapy (OT) and Physical Therapy (PT) services. The ABN did not include other potential financial liability or services that may no longer be covered by Medicare, such as room and board. Resident #14 (R14):Review of the medical record reflected R14 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included diabetes and dementia. Facility documentation reflected R14 exhausted their Medicare Part A benefit days, and beginning 10/7/24, they may have had to pay out of pocket for OT, PT and daily skilled nursing care. The ABN form reflected the cost per 15 minutes of services. The ABN did not include other potential financial liability or services that may no longer be covered by Medicare, such as room and board. In an interview on 01/08/25 at 4:18 PM, Business Office Manager (BOM) J indicated it made sense that room and board charges would be included on an ABN, however, that was not how they had been taught.

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview, and record review the facility failed to provide necessary care to two of five residents (R22 and R31) reviewed for activities of daily living (ADLs), resulting in these residents not receiving the care needed to maintain their highest practicable well-being. Findings include: Resident #31 (R31) Review of the medical record reflected R31 was an initial admission to the facility on [DATE]. Diagnoses of Anoxic Brain Damage (brain injury happens when your brain loses oxygen supply), Dry Mouth, Major depression, Contracture of right hand (when one or more fingers bend toward the palm of the hand), Neuromuscular Dysfunctionof Bladder (when neurological (nervous system) conditions affect the way your bladder works), Dysphagia (difficulty in swallowing), Gastrostomy Tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) and Post-Traumatic Hydrocephalus (is a frequent and serious complication that follows a traumatic brain injury (TBI). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2024, revealed R31 had a Brief Interview of Mental Status (BIMS) of 11 (moderately intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 was dependent on all care. During an interview on 01/06/25 at 12:45 PM, R31's family R stated R31 had built up around his teeth and what appears to be hanging substance from his back teeth and his tongue covered with a white buildup. R31's family member R also stated she did not feel the staff were brushing his teeth like they should be. R31's family R also stated staff are supposed to be putting a rolled washcloth rolled up in his right hand to keep the fingers from digging into his palm. Record review revealed R31' s care plan included wash and dry right hand every shift and place palm protector or rolled wash cloth between the palm and his fingers. During an observation on 01/06/25 at12:50 PM, R31 had a buildup that appeared to be plaque around teeth and what appears to be stringy substance hanging from his back teeth. R31's tongue was covered with a white, dry buildup. R31's gums were swollen and inflamed. Observation of R31 laying in his bed with the head of his bed elevated approximately 45 degrees to accommodate tube feeding. R31's feet were not floating on a pillow and his feet were rubbing against the foot board. R31's right hand was contracted, and his fingers were bend tightly against his palm. No observation of a rolled washcloth or device to keep his fingers from digging into his palm or to absorb moisture. During an observation on 01/06/25 at 4:30PM, R31 was laying in the same position as 12:45 PM today, in his bed with the head of his bed elevated approximately 45 degrees to accommodate tube feeding. R31's feet were not floating up off the mattress and his feet rubbing up against the foot board. R31's right hand was contracted, and his fingers were bend tightly against his palm. No observation of a rolled washcloth or device to keep his fingers from digging into his palm or to absorb moisture. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/07/25 at 9:00 AM, R31 was laying in his bed with the head of his bed elevated approximately 45 degrees. R31's feet were not floating off the mattress and his feet were pushed up against the foot board. R31's right hand was contracted, and his fingers were bend tightly against his palm. No observation of a rolled washcloth or device to keep his fingers from digging into his palm or to absorb moisture. During an observation on 01/07/25 at 1:00PM, R31 was laying in his bed with the head of bed elevated approximately 45 degrees to accommodate tube feeding. R31's feet were not floating on a pillow or up off the mattress. R31's feet were pressed up against the foot board. R31 had been in the same position for the last four hours with no changes in his position in the bed. During an observation on 01/07/25 at 4:00PM, R31 was laying in the same position in his bed, feet were not floating, feet firm against the foot board. During an interview and observation on 01/07/25 at 12:33 PM, Licensed Practical Nurse (LPN) B, stated she came in do oral care for R31, looked around for supplies, didn't have any in the room, she had to go out of the room to gather supplies. This writer could observed build up on his teeth, gum line puffy, same condition as yesterday, with stringy stuff hanging off his back teeth. LPN B returned to his room with oral care supplies. LPN B used a sponge on a stick, dipped in mouth wash to do oral care. LPN B stated he had a hard thing in the roof of his mouth, and she finally got it out. During this same observation, LPN B was touching and moving his gastrostomy tube and clamp without PPE for enhanced barrier precaution. The sign on this resident's door stated he was on enhanced barriers precautions and required gown and gloves for staff providing any care. LPN B covered him back up and told him she had to go get supplies. During an interview and observation on 01/07/25 at 12:50 PM, LPN B hung his tube feeding, did not start the infusion pump, wearing gloves but no gown. LPN B removed gloves and exited the room, no hand hygiene observed after removal of her gloves. LPN B came back into R31's room, put new gloves on and checked the gastric residual (amount of enteral feeding left in the stomach from the last feeding) again with gloves but no gown. LPN B stated R31 did not have any gastric residual left in his stomach. However, this writer was unable to see over the side of his bed due to LPN B being so close to the resident's side performing that task. LPN B took her gloves off and put new gloves on to clean off the over the bed table. During an interview on 01/07/25 at 3:27 PM, Social Worker (SW) D stated she does follow up after appts such as dental, if more appointments are needed. Writer asked her if there were any follow up appointments made on R31's teeth as the dentist documented he had heavy plaque and cavities. SW D stated she would have to investigate it and wound let writer know. Record review revealed R31 got a shower on Tues and Fri nights. Does not reflect that he had a shower last night (Tuesday night, 01/07/25). R31 does have hospice services so the hospice CNA would be providing care through the week as well. Record review of care plan revealed R31 is care planned for Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily. Turn/reposition every 2 hours and prn. Observe/document/report to physician PRN s/sx of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/25 at 4:27 PM, writer asked LPN B what the medication left at the bedside of R31 was used for, as there was no name on it, no date on it, nor an order for it in the electronic medical record (EMR). LPN B stated there had to be an order for it since they have been using it. LPN B stated she would direct this concern to the RN/Unit Manager M. During an interview on 01/07/25 at 4:35 PM, RN/Unit Manager M was observed looking in her computer for an order for Bio-[NAME] medication. RN/Unit Manager M stated there was not an order, it must have dropped off. RN/Unit Manager asked writer if she should put an order in for the Bio-[NAME] medication? Writer stated I cannot tell you what to do, but it would make sense to have an order for any medications that were given or being used. Record review of physician orders on 01/08/25 at 8:04 AM, revealed a new order put in on 01/07/25 at 6:00 PM for (Bio-[NAME] Dry Mouth Moisturizing Mouth/Throat Solution. Give 1 application by mouth every 4 hours for xerostomia may have at bedside) During an observation on 01/08/25 at 8:24 AM, the bottle of the medication Bio-[NAME] was still setting on R31's dresser without any name, date opened or instructions for this medication on it. During an interview on 01/08/25 at 8:26 AM, SW D stated R31 saw the dentist in 03/24 and 10/24. SW D stated the dentist recommendation was for staff to assist with oral care and use a toothbrush. Writer asked if R31 had any additional follow up appointments with the dentist, and SW D stated she didn't know, but she would check. Record review of the dental visit notes dated 10/09/24 recommendation was for staff to brush his teeth and do oral care due to the buildup of plaque. During an observation on 01/08/25 at 8:34 AM, R31's wash basin with hygiene products, did not have a toothbrush in it, only a small tube of toothpaste was present. During an interview on 01/08/25 at 8:50 AM, Certified Nursing Assistant (CNA) N stated she uses a sponge on a stick to do oral care on R31. During an interview on 01/08/25 at 8:52 AM, CNA O stated she cleans R31's teeth with a sponge on a stick, dipped in mouthwash. During an interview on 01/08/25 at 8:51 AM, CNA P, stated she usually cleans R31's mouth with a sponge on a stick and tries to clean his teeth off with that. During an interview on 01/08/25 at 8:58 AM, Registered Nurse (RN) C stated she used a sponge on a stick to get the plaque buildup off, and sometimes she uses a toothbrush. RN C added R31 is a tough one due to the plaque buildup on his teeth. RN C also stated she uses the Bio-[NAME] to keep his mouth moist. Record review revealed R31' s care plan included wash and dry right hand every shift and place palm protector or rolled wash cloth between the palm and his fingers. 49272 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22 (R22) Review of the medical record reflected that R22 was initially admitted to the facility on [DATE] with diagnoses that included: major depressive disorder, anxiety disorder, intermittent explosive disorder, muscle weakness and difficulty in walking. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/24, revealed R22 had a Brief Interview of Mental Status (BIMS) of 15 out of 15, which indicated intact cognition. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R22 required substantial/maximal assistance for showering, partial/moderate assistance with upper body dressing and substantial/maximal assistance with lower body dressing. During an observation on 1/6/25 at 1:01 PM, R22 was observed to have greasy, uncombed hair and reported that he had only received 3 showers since he had been here. R22 reported that the staff does not offer him a shower twice weekly. It should be noted that resident was in isolation requiring an N-95 mask to be worn, unable to determine if odor was present. During an observation on 1/8/25 at approximately 2pm, R22 was observed in the hallway, hair remained greasy and uncombed. A review of R22's shower task revealed only one shower documented in a 30-day time span (12/16/24 through 1/6/25), one refusal documented and Not Applicable documented 5 times. Record review revealed R22's shower days should be Monday and Thursday each week. During an interview with Unit Manager (UM) M on 1/8/25 at 2:21PM, she reviewed R22's shower task log for the past 30 days and stated it looked bad. UM M was asked when it would be appropriate to document Not Applicable on the shower task, she reported it would never be appropriate, and that staff should be offering and documenting showers or refusals twice weekly. When asked if the unit managers audit shower and shower related tasks she reported she is new to the role (2 months) and they are working hard on getting everything to match (paper shower sheets that indicate which residents are due for showers each day and task information in the electronic medical record). She further stated that they have not gotten to audits yet but they have done education on charting and 1:1's. Review of the facilities policy titled Activities of Daily Living (ADL) Program updated 4/24, documented in part A resident requiring skill practice and/or training in activities of daily living (ADL) is evaluated for restorative nursing. ADL may include, but are not limited to, bathing, grooming, and dressing. Restorative ADL program may be provided by nursing assistants and other staff trained in provision of ADL care under the supervision of the licensed nurse.

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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** 49272 Based on observation, interview, and record review the facility failed to provide pressure ulcer treatments as ordered for one (Resident 54) of three reviewed, resulting in the potential of a worsened pressure ulcer. Findings include: Review of the medical record reflected that R54 was initially admitted to the facility on [DATE] with diagnoses that included: Periprosthetic (relating to an artificial joint) fracture around internal prosthetic (artificial) right knee joint, morbid obesity, Parkinson's disease, heart failure and muscle weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/24, revealed R54 had a Brief Interview of Mental Status (BIMS) of 12 out of 15, which indicated moderate cognitive impairment. On 1/6/25 at 10:37 AM R54 was observed sitting up at the edge of her bed. A soiled pillow/pillowcase was observed at the foot of R54's bed with brown/yellow colored stain. When asked what the substance was on the pillowcase she reported that she believed it was drainage from the dressing on her right heel and added that the staff isn't good about changing her dressing every day and she was told it was supposed to be changed each day. On 1/6/25 at 10:46 AM, CNA A applied gloves and removed R54's sock to reveal 2 dressings to R54's lateral foot and heel on her right foot. Dressings were dated 1/4/25. CNA A confirmed the date on the dressing was 1/4/25. A review of R54's physician orders revealed the following wound care orders: Wound care to right lateral outer ankle: cleanse with wound wash, pat dry, apply skin prep to reddened skin, cover with a gently border foam gauze daily and as needed, with a start date of 12/27/2224. Wound care to right posterior ankle: Cleanse wound with wound wash, pat dry, apply Medihoney to wound, apply skin prep peri wound, cover with gentle border foam gauze daily and as needed with a start date of 12/20/24. A review of R54's Treatment administration record revealed wound care was documented as completed by LPN B. An attempt was made to contact LPN B on 1/8/25 via phone at 12:22 PM. No return call was received prior to survey exit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 12:38 PM an interview was conducted with Director of Nursing (DON) and Nursing Home Administrator (NHA). When notified of dressing change not completed for R54 on 1/5/25 but documented as completed on the TAR, they reported that they were aware and had spoken with LPN B and provided 1:1 education. LPN B was educated on not documenting a task that hasn't been completed. DON stated that LPN B stated that she passed on to the oncoming nurse that the dressing change had not been done. DON stated that the expectation for documenting is that it should be completed immediately after the task had been completed. Review of the facilities policy titled Documentation Expectations updated 6/23, documented in part Chart events as they occur and maintain chronological order .If a medication or treatment is not administered as ordered, the nurse circles the appropriate box and enters the reason for omission per facility policy .Entries in the medical record should be completed in a timely manner. Entries should be made at the time of the occurrence .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview, and record review the facility failed to ensure for one out of 15 residents (Resident #31) medications were properly and safely stored, labeled with resident's name, date opened, and physician's order for administration. Findings include: Resident #31 (R31) Review of the medical record reflected R31 was an initial admission to the facility on [DATE]. Diagnoses of Anoxic Brain Damage (brain injury happens when your brain loses oxygen supply), Dry Mouth, Major depression, Contracture of right hand (when one or more fingers bend toward the palm of the hand), Neuromuscular Dysfunctionof Bladder (when neurological (nervous system) conditions affect the way your bladder works), Dysphagia (difficulty in swallowing), Gastrostomy Tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) and Post-Traumatic Hydrocephalus (is a frequent and serious complication that follows a traumatic brain injury (TBI). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2024, revealed R31 had a Brief Interview of Mental Status (BIMS) of 11 (moderately intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 was dependent on all care. Concern r/t no physician order for medication for R31, and potential to affect all residents (1 of 60) During an interview on 01/07/25 at 4:27 PM, writer asked LPN B what the medication left at the bedside of R31 was used for, as there was no name on it, no date on it, nor an order for it in the electronic medical record (EMR). LPN B stated there had to be an order for it since they have been using it. LPN B stated she would direct this concern to the RN/Unit Manager M. During an interview on 01/07/25 at 4:35 PM, RN/Unit Manager M was observed looking in her computer for an order for Bio-[NAME] medication. RN/Unit Manager M stated there was not an order, it must have dropped off. RN/Unit Manager asked writer if she should put an order in for the Bio-[NAME] medication? Writer stated I cannot tell you what to do, but it would make sense to have an order for any medications that were given or being used. Record review of physician orders on 01/08/25 at 8:04 AM, revealed a new order put in on 01/07/25 at 6:00 PM for (Bio-[NAME] Dry Mouth Moisturizing Mouth/Throat Solution. Give 1 application by mouth every 4 hours for xerostomia may have at bedside) During an observation on 01/08/25 at 8:24 AM, the bottle of the medication Bio-[NAME] was still setting on R31's dresser without any name, date opened or instructions for this medication on it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview, and record review the facility failed to ensure for one out of 15 residents (Resident #31) medications were properly and safely stored, labeled with resident's name, date opened, and physician's order for administration. Findings: Resident #31 (R31) Review of the medical record reflected R31 was an initial admission to the facility on [DATE]. Diagnoses of Anoxic Brain Damage (brain injury happens when your brain loses oxygen supply), Dry Mouth, Major depression, Contracture of right hand (when one or more fingers bend toward the palm of the hand), Neuromuscular Dysfunctionof Bladder (when neurological (nervous system) conditions affect the way your bladder works), Dysphagia (difficulty in swallowing), Gastrostomy Tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) and Post-Traumatic Hydrocephalus (is a frequent and serious complication that follows a traumatic brain injury (TBI). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2024, revealed R31 had a Brief Interview of Mental Status (BIMS) of 11 (moderately intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 was dependent on all care. During an interview on 01/07/25 at 4:27 PM, writer asked LPN B what the medication left at the bedside of R31 was used for, as there was no name on it, no date on it, nor an order for it in the electronic medical record (EMR). LPN B stated there had to be an order for it since they have been using it. LPN B stated she would direct this concern to the RN/Unit Manager M. During an interview on 01/07/25 at 4:35 PM, RN/Unit Manager M was observed looking in her computer for an order for Bio-[NAME] medication. RN/Unit Manager M stated there was not an order, it must have dropped off. RN/Unit Manager asked writer if she should put an order in for the Bio-[NAME] medication? Writer stated I cannot tell you what to do, but it would make sense to have an order for any medications that were given or being used. Record review of physician orders on 01/08/25 at 8:04 AM, revealed a new order put in on 01/07/25 at 6:00 PM for (Bio-[NAME] Dry Mouth Moisturizing Mouth/Throat Solution. Give 1 application by mouth every 4 hours for xerostomia may have at bedside) During an observation on 01/08/25 at 8:24 AM, the bottle of the medication Bio-[NAME] was still setting on R31's dresser without any name, date opened or instructions for this medication on it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49103 Based on observation and intrview the facility failed to maintain safe food temperatures affecting all 61 residents with the potential for causing food-related illnesses. Findings include: On 1/6/25 at 12:45 PM during second tour of the facility kitchen the plating of food was observed. Following the plating of food done by the cook S the remaining food still on the steam table was immediately tested for temperature. The cook S utilized the kitchen thermometer. The food temperatures in degrees farenheight were as follows: Cream of Potato Casserole: 128 Peas: 90 Fish: 120 Green Beans 140 Mashed Potatoes 130 Gravy 135 Garlic Bread: 80 The cook S acknowledged the low readings and said the temperature readings would be addressed with administration. On 01/07/25 12:55 PM during interview the Consultant Dietician U said the low temperatures had been communicated (and the Dietary Manager (DM) T and CD U were communicating via email during the iterview) and CD U said DM T would address the problem of food being . not up to temperature. On 01/08/25 02:02 PM during observation of the pantry DM T was interviewed. DM T explained the refrigerator in the pantry is a main pantry used by all residents in the facility. The refrigerator temperature gauge was checked and showed a reading of 44 degrees. DM T was asked about the acceptable range which DM T stated as 32 to 41 degrees. DM T said that the temperature is monitored daily. A form secured to the refrigerator showed temperatures for the month of January consistently documented as 40 degrees. DM T was asked about actions to be taken when there is an out of range reading and responded by saying that there could be reasons the temperature was not at the required level. DM T said she would typically confirm the door was sealing shut and would return in an hour to check the temperature. If the temperature was found to be out of range the next step would be to transfer food to the backup refrigerator in therapy department. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235569	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ovid Healthcare Center	9480 E M-21 Ovid, MI 48866

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/8/25 at 2:48 PM during second observation the pantry refrigerator temperature registered at 60 degrees. A dietary employee had just exited the room after having washed the inside of the refrigerator. On 1/8/25 at 2:55 PM the DM T and a dietary employee pulled a large plastic container of turkey sandwiches out of the refrigerator. DM T instructed the dietary employee that each layer of sandwiches would be checked for temperature and all products in the refrigerator would be checked and anything not within an acceptable level of temperature would be discarded and all food that was within range would be transferred to the backup refrigerator. The turkey sandwiches were testing at around 50 degrees F. Following that another container of cheese sandwiches was tested which tested at around 46 degrees F. DM T said these would all need to be discarded. The NHA A was present in the room. The testing continued. There were many products in the refrigerator. According to a facility policy titled Food Temperatures with a date of revision of 12/12/21 states in part, The temperature of holding hot foods at point of service will be > 130 degrees F. The temperature of holding cold foods at point of service will be < 41 degrees F. The cook is responsible for ensuring all food is at the proper serving temperature. Food temperatures will be taken and recorded for all TCS foods at all meals. According to an article on USDA.gov (United States Department of Agriculture) website the temperature of food at safe levels prevents foodborne illness.

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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** 38383 Based on observation, interview and record review, the facility failed to 1) implement Enhanced Barrier Precautions for one (Resident #31); and 2) implement measures to mitigate the spread of COVID-19 infection to facility staff and residents. During an interview on 01/08/25 at 8:50 AM, with the Director of Nursing (DON) and Infection Preventionist (IP) I (in attendance via phone), it was reported that the facility's COVID-19 outbreak was believed to have started after Registered Nurse (RN) K tested positive for COVID-19 (on 12/30/24). It was reported that facility-wide COVID-19 testing was initiated for all residents and staff, as RN K had worked all over the facility, and they were unable to determine close contacts. It was reported the first residents tested positive for COVID-19 on 12/31/24. Review of a facility surveillance log reflected RN K had symptoms of stuffy nose, dry cough and body aches, which began on 12/28/24. RN K had a positive result on a COVID-19 test on 12/30/24. A time card report for RN K reflected they worked from 5:56 PM on 12/28/24 to 6:47 AM on 12/29/24, for a total of 12.25 hours. RN K worked from 5:56 PM on 12/29/24 to 7:38 AM on 12/30/24, for a total of 13.25 hours. According to Centers for Disease Control and Prevention (CDC), .Symptoms of COVID-19 .People with COVID-19 have a wide range of symptoms ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Symptoms may start as mild, and some people will progress to more severe symptoms .Possible symptoms include: .Cough .Sore throat .Muscle or body aches . (https://www.cdc.gov/covid/signs-symptoms/index.html In an interview with the Nursing Home Administrator (NHA) and DON on 01/08/25 at 3:48 PM, it was reported that RN K worked while experiencing symptoms that could have been consistent with COVID-19 but did not notify the facility. The facility became aware of RN K's symptoms after they tested for COVID-19 (on 12/30/24). According to the facility's COVID-19 infection surveillance logs, 31 residents had tested positive for COVID-19 between 12/31/24 and 1/8/25, and 23 staff had tested positive for COVID-19 between 12/30/24 and 1/7/25. During an interview with the DON and IP I (who attended via phone) on 1/08/25 at 1:43 PM, it was reported if staff were experiencing symptoms consistent with COVID-19, they were to notify the facility, which included the DON and IP I. It was reported that staff were to come to the facility for COVID-19 testing, outdoors. Staff were not to report to work if they were symptomatic. 45135 Resident #31 (R31) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record reflected R31 was an initial admission to the facility on [DATE]. Diagnoses of Anoxic Brain Damage (brain injury happens when your brain loses oxygen supply), Dry Mouth, Major depression, Contracture of right hand (when one or more fingers bend toward the palm of the hand), Neuromuscular Dysfunctionof Bladder (when neurological (nervous system) conditions affect the way your bladder works), Dysphagia (difficulty in swallowing), Gastrostomy Tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) and Post-Traumatic Hydrocephalus (is a frequent and serious complication that follows a traumatic brain injury (TBI). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2024, revealed R31 had a Brief Interview of Mental Status (BIMS) of 11 (moderately intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R31 was dependent on all care. During an interview and observation on 01/07/25 at 12:33 PM, Licensed Practical Nurse (LPN) B, stated she came in do oral care for R31, looked around for supplies, didn't have any in the room, she had to go out of the room to gather supplies. This writer could observed build up on his teeth, gum line puffy, same condition as yesterday, with stringy stuff hanging off his back teeth. LPN B returned to his room with oral care supplies. LPN B used a sponge on a stick, dipped in mouth wash to do oral care. LPN B stated he had a hard thing in the roof of his mouth, and she finally got it out. During this same observation, LPN B was touching and moving his gastrostomy tube and clamp without PPE for enhanced barrier precaution. The sign on this resident's door stated he was on enhanced barriers precautions and required gown and gloves for staff providing any care. LPN B covered him back up and told him she had to go get supplies. During an interview and observation on 01/07/25 at 12:50 PM, LPN B hung his tube feeding, did not start the infusion pump, wearing gloves but no gown. LPN B removed gloves and exited the room, no hand hygiene observed after removal of her gloves. LPN B came back into R31's room, put new gloves on and checked the gastric residual (amount of enteral feeding left in the stomach from the last feeding) again with gloves but no gown. LPN B stated R31 did not have any gastric residual left in his stomach. However, this writer was unable to see over the side of his bed due to LPN B being so close to the resident's side performing that task. LPN B took her gloves off and put new gloves on to clean off the over the bed table. LPN B removed the gloves and exited the room without washing her hands.