STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235601	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron River Care Center	330 Lincoln Ave Iron River, MI 49935

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 49735 Based on interview and record review, the facility failed to provide responses to concerns/grievances for 4 Confidential Residents (CR301, CR302, CR303, CR305) reported during the Resident Council survey task. This deficient practice has the potential to result in unresolved resident concerns and a decreased quality of life. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted.) During a confidential group meeting on 8/27/24 at 11:00 a.m., CR301 stated, we have a lot of the same complaints during resident council and they don't get taken care of. CR302 CR303, and CR305 all agreed. CR302 stated, We have the same concerns every month during resident council .we never hear anything back from the concerns we have, nothing changes. During an interview on 8/28/24 at 8:51 a.m., the Activity Director reviewed the resident council minutes and stated, I am not doing a very good job of reviewing the concerns and documenting them .I guess I could do a better job in charting the concerns or when they are reviewed with the resident council. Review of facility policy titled Resident Council Meeting last revised dated, 6/22/24 .read in part, the Activity Director shall be designated .to serve as a liaison .the liaison shall be responsible for .responding to written requests from the group meetings .the facility shall act upon concerns and recommendations .and communicate decisions to the council. 40383 The Resident Council meeting minutes were reviewed. The 6/12/24 meeting minutes New Business included a quote by one of the residents which read, The food tastes good and much improved, but it is still cold. There was not a Resident Council meeting in the month of July 2024. The Resident Council meeting minutes dated 8/1/24 revealed the Old Business section was the same as the Old Business from the 6/12/24 meeting and the items discussed as new business from that 6/12/24 meeting had not been carried forward. Many of the concerns brought up at the last meeting 6/12/24 including cold food were not noted in the 8/1/24 minutes as discussed or resolved.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on interview and record review, the facility failed to report and allegation of potential sexual abuse between two Residents (Residents #3 and #205) of four residents reviewed for abuse. This deficient practice resulted in the potential for undetected abuse. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted.) Resident #3 (R3) Review of R3's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: anxiety disorder, depression, heart failure, and hypertension. R3 scored 8 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderate cognitive impairment. Resident #205 (R205) Review of R205's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: coronary artery disease, hypertension, non-Alzheimer's dementia, and depression. R205 scored a 3 of 15 on the BIMS assessment reflective of severe cognitive impairment. Review of a resident grievance form, dated 3/2/24, under the section, Nursing Grievances, read in part . R3 stated, R205 tried to get into my bed again at 1 o'clock in the morning. R3 screamed and they just keep telling me that R205 is harmless .everyday R205 tries to get into my bed .this needs to stop. During an interview on 8/28/24 at 9:34 a.m., Social Services Designee I stated R205 was going into R3's room .I did report it to the Director of Nursing (DON) and the Nursing Home Administrator (NHA). During an interview on 8/28/24 at 9:57 a.m., the DON stated, I did not personally report the event .I don't know if it was reported by the NHA .I can't tell you if it was reported to the SA. During an interview on 8/28/24 at 10:07 a.m., the NHA stated I did not find any investigation into this grievance . it was not reported. Review of R3's and R205's Electronic Medical Record (EMR) revealed no documentation of the event. Review of facility policy titled Resident and Family Grievances date reviewed/revised . 2/1/24, read in part . for investigations regarding allegations of .abuse .a report of the investigative results will be submitted to the State Survey Agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Iron River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 330 Lincoln Ave Iron River, MI 49935	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Abuse, Neglect and Exploitation date reviewed/revised . 4/15/24, read in part . The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations to the state survey agency and other officials in accordance with state law .The facility will have written procedures that include reporting all alleged violations to the .state agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on interview and record review, the facility failed to investigate an allegation of potential sexual abuse between two Residents (Residents #3 and #205) of four residents reviewed for abuse. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted.) Resident #3 (R3) Review of R3's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: anxiety disorder, depression, heart failure, and hypertension. R3 scored 8 of 15 on the Brief Interview of Mental Status (BIMS) reflective of moderate cognitive impairment. Resident #205 (R205) Review of R205's MDS assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: coronary artery disease, hypertension, non-Alzheimer's dementia, and depression. R205 scored a 3 of 15 on the BIMS assessment reflective of severe cognitive impairment. Review of a resident grievance form, dated 3/2/24, under the section, Nursing Grievances, read in part . R3 stated, R205 tried to get into my bed again at 1 o'clock in the morning. R3 screamed .they just keep telling me that R205 is harmless .everyday R205 tries to get into my bed .this needs to stop. During an interview on 8/28/24 at 10:07 a.m., the Nursing Home Administrator (NHA) stated I did not find any investigation into this grievance. Review of R3's and R205's Electronic Medical Record (EMR) revealed no documentation of the event. Review of facility policy titled Resident and Family Grievances date reviewed/revised . 2/1/24, read in part . The NHA and/or Social Service Designee have been designated as the grievance official. The grievance official is responsible for .leading any necessary investigations by the facility .report any allegations involving . abuse .immediately to the NHA. Review of facility policy titled Abuse, Neglect, and Exploitation date reviewed/revised . 4/15/24, read in part . An immediate investigation is warranted when suspicion of abuse .or reports of abuse .occur .written procedures for investigations include identifying staff responsible for the investigation .investigating different types of alleged violations .providing complete and thorough documentation of the investigation.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on interview and record review, the facility failed to provide written transfer notification to the Resident and/or Resident's Representative for two Residents (R7 and R15) of three residents reviewed for facility initiated transfers. Findings include: Resident #7 (R7) was transferred to the hospital on 7/19/24. The medical record did not indicate a written notification of transfer was provided to R7 or R7's resident representative. Resident #15 (R15) was transferred to the hospital on 6/27/24. The medical record did not indicate a written notification of transfer was provided to R15 or R15's resident representative. On 8/28/24 at 12:45 p.m., the Nursing Home Administrator (NHA) conveyed the facility did not issue the written notifications to R7 or R15 or their resident representatives when the residents were transferred to the hospital. On 8/28/24 at 2:40 p.m., the Corporate Director of Clinical Services (DCS) confirmed written notifications of transfer were required and provided a policy Transfer and Discharge (including AMA) dated 8/7/22. The policy read, in part: .transfer/discharge notice will be provided to the resident and the resident's representative .when the transfer or discharge is effected because .an immediate transfer or discharge is required by the resident's urgent medical needs .the notice must be provided to the resident, resident's representative if appropriate, and LTC (Long Term Care) ombudsman as soon as practicable before the transfer or discharge .

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted Based on interview and record review, the facility failed to ensure two Residents (R7 and R15) of three residents reviewed for hospital discharges, were provided with written notification of the bed hold policy. Findings include: Resident #7 (R7) was transferred to the hospital on 7/19/24. The medical record did not indicate the bed hold policy was provided to R7 or R7's resident representative. Resident #15 (R15) was transferred to the hospital on 6/27/24. The medical record did not indicate the bed hold policy was provided to R15 or R15's resident representative. On 8/28/24 at 12:45 p.m., the Nursing Home Administrator (NHA) said the facility did not provide the bed hold policy to R7 or R15 or their representatives when the residents were transferred to the hospital. The facility policy Bed Hold Policy dated 5/28/24 read, in part: .At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered and trauma-informed care plan for one Resident (#41) of one resident reviewed for mood and behaviors, resulting in the potential for psychosocial distress and decreased quality of life. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. Resident #41 (R41) R41 was admitted to the facility on [DATE] with a primary diagnosis of dementia with behavioral disturbance. Review of R41's Minimum Data Set (MDS) assessment, dated 6/9/2024, revealed severe cognitive impairment and was assessed as being easily annoyed and short tempered . 12-14 days (nearly every day), during the assessment look back period. R41 was assessed as exhibiting the following behavior symptoms 1-3 days of the look back period: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing .); verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others); and other behavioral symptoms not directed toward others (e. g., physical symptoms such as hitting or scratching self, pacing, rummaging, disrobing in public, throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, disruptive sounds). During an interview on 8/27/2024 at 10:21 a.m., R41's spouse, Family Member (FM) J reported R41 was easily angered, agitated and often lashed out at others out of fear. FM J stated he believed the behavior stemmed from a history of severe physical abuse at the hands of R41's former partner. R41 reported the facility was aware of R41's history of abuse and what he believed to be the resulting behavioral symptoms. FM J reported R41 may misinterpret hurried activities and sudden movements toward her as aggressive and threatening. Review of R41's electronic medical record (EMR) from date of admission on 4/17/2023 through 8/27/2024, revealed no documented trauma assessment upon admission or any time after admission for R41. Review of R41's comprehensive care plan revealed no focus area, goals or person-centered interventions related to her history of trauma, physical abuse or potential triggers. During an interview on 8/28/24 at 9:21 a.m., Social Services Director, (SW) I reported she was aware of R41's history of abuse. SW I stated she had lengthy discussions with FM J about R41's history, but a trauma assessment was never conducted as she was new to the Social Services role. During a review of R41's EMR at the time of the interview, SW I confirmed R41 was never assessed for past trauma and an appropriate care plan, including focus area, goals and interventions was never developed for trauma-informed care. SW I stated every resident with a history of trauma or current trauma should be assessed and appropriate, person-centered interventions put in place to address the resident's needs and avoid re-traumatization. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Iron River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 330 Lincoln Ave Iron River, MI 49935	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Trauma Informed Care, last reviewed 6/29/2023, revealed the following, in part: Trauma result from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individuals' functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to . physical, sexual, mental, and/or emotional abuse (past or present) . A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms in residents and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization . The facility will use a multi-pronged approach to identifying a resident's history of trauma . asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools, history and physical, the social history/assessment . the facility will collaborate with resident trauma survivors, the resident's family, friends, the primary care physician and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on interview and record review, the facility failed to ensure safe resident handling during transfers for one Resident (#18) of one resident reviewed for accidents, resulting in a skin tear and the potential for serious injury. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. Resident 18 (R18) R18 was admitted to the facility on [DATE] and had diagnoses including dementia, difficulty walking and muscle weakness. Review of R18's Minimum Data Set (MDS) assessment dated [DATE], revealed she required substantial/maximal assistance with sitting to standing, chair/bed-to-chair, toilet and shower/tub transfers. Further review of R18's MDS assessment revealed she had severe cognitive impairment and highly impaired hearing. Review of R18's electronic medical record (EMR) revealed the following: 8/25/2024 6:35 p.m. Central Daylight Time (CDT), Incident Note: This writer went in to give the resident her am medication as [Certified Nursing Assistant, CNA N] was just completing her am [morning] cares. [CNA N] expressed she [R18] got a skin tear. I noted that her clothing was on and had long sleeves, I asked the [CNA N] where the skin tear was and noted that her left arm sleeve had blood coming through the fabric. [CNA N] said her arm hit the side of the door jam [sic] when she was bringing her into the bathroom. I then asked why her clothes were put on after the skin tear. [CNA] expressed that the resident was, all over the place. [CNA N] expressed that she was in a hurry. Resident is labile this morning, she is usually very talkative, but she said nothing thus far, since being up. She would not open her eyes when I asked her questions about pain. She took her meds and then put her head down and closed her eyes in her w/c [wheelchair], at this time. I assessed the wound and questioned the [CNA N] as I did not understand why the resident's clothing sleeve was over the skin tear as it is quite large. I cleansed the area and applied steri strips, even though the skin had been pushed together from her long sleeve shirt that was applied after the injury. I then covered it with a non-stick dressing and wrapped with kerlix. Review of R18's incident report titled New Skin Condition, dated 8/25/2024, revealed the following: [CNA N], 8/25/2024 . was transferring [R18] into bathroom, resident became limp, and I hurried onto toilet because I didn't want her to fall . she was unable to sit straight . noticed skin tear on left arm. I'm assuming she hit door jam. Had to get [two] more [CNAs] to get her off [toilet]. [(LPN)Licensed Practical Nurse O], 8/25/2024 . noted a large skin tear to the left forearm, with dark purple bruising surrounding the whole area . resident was transferred with the sit to stand machine, her [care plan] states a [total mechanical lift] is to be used due to the last fall she had out of the sit to stand. Further review of R18's EMR revealed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/12/2024 3:15 p.m. CDT, Incident Note Late Entry: This writer was summoned to resident's room, noted resident lying on the floor next to her bed and another was holding up her head. Noted a bump forming to the right back side of head. Per [CNA P], she was using the sit to stand lift and when she turned to put the resident in the chair, resident slid out and fell . This writer was summoned to resident's room, noted resident lying on the floor next to her bed and another nurse was holding up her head. Noted a bump forming to the right back side of head. Per [CNA P], she was using the sit to stand lift and when she turned to put the resident in the chair, resident slid out and fell . Resident was assessed and noted that she had no complaints with ROM, noted that her hips were equally aligned, and she did not have any s/s (signs/symptoms) of pain. VSS [vital signs stable]. Ice was applied to the bump forming on the right side of the back of her head and it did flatten out after 1.5 hours of ice application & [and] did note discoloration/pinkish/red/bruise. Review of R18's incident report titled Fall with Injury, dated 6/12/2024, revealed the following: [LPN O], 6/12/2024, I was summoned to the resident's room by the [CNA P] who was the witness to the fall out of the sling on the sit to stand assistive transfer lift . Resident was lying on her right side next to her bed. The lift sling was observed to be still attached to the lift on the left side. Further review of R18's EMR revealed no therapy evaluation for determination of appropriate transfer status following R18's fall from the sit to stand lift on 6/12/2024 or prior to the incident during use of the sit to stand lift when transferred to the toilet on 8/25/2024. Review of R18's care plan revealed the following: Alteration in physical functioning . I have generalized weakness, as well as limitations with upper and lower extremity [range of motion], Date Initiated: 3/18/2020 . Interventions/Tasks: Extensive assist x 1 with transfers via sit to stand, Date Initiated: 3/18/2020, Date Resolved: 8/05/2024 Transfer assist x 2 with Hoyer [total mechanical lift]. Dated initiated: 11/07/2020 . It was noted in review of R18's care plan, the intervention for use of the total mechanical lift for R18's transfers initiated on 11/07/2020, was added after the intervention for the use of the sit to stand lift was initiated on 3/18/2020 and remained active following resolution of the use of the sit to stand lift on 8/05/2024. Further review of R18's care plan revealed the following: At risk for falls [due to] decreased mobility/generalized weakness, limitations with [range of motion], [history] of falls and poor hearing and vision, Date Initiated: 3/18/2020 . Interventions/Tasks: Total assist x 2 with transfers. Use Hoyer [total mechanical lift] with sling. Date Initiated: 3/18/2020. Date Canceled: 8/27/2024. It was noted the intervention for use of the total mechanical lift was not canceled until after both of R18's incidents during transfer with the sit to stand lift on 6/12/2024 and 8/25/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/24 at 2:24 p.m., the DON reported she was unaware R18 was care planned for use of a total mechanical lift for transfers and fall prevention. The DON stated she was unsure why there were conflicting interventions on R18's care plan. The DON reported the cause of the fall from the sit to stand on 6/12/2024 was determined to be inappropriate attachment of the sling to the lift and stated CNA P did not ensure the sling was secured to the lift prior to initiating the transfer and R18 was unable to support herself. During an interview on 8/28/2024 at 3:20 p.m., CNA P confirmed she alone was transferring R18 to the toilet when R18 fell from the sit to stand lift on 6/12/2024. CNA P stated the sling came loose and pulled away from the lift, dropping R18 and breaking the buckle around the brace secured around the Resident's torso. R18 was unable to bear weight or hold onto the lift handles. CNA P reported she was unsure what R18's care planned transfer status was at the time of the fall and added but we always used the sit to stand lift. During review of R18's therapy evaluations on 8/28/2024 at 2:34 p.m., with Physical Therapy Assistant (PTA) Q, revealed R18 was evaluated on 1/13/2023 and 3/9/2023. PTA Q reported R18 was determined to need substantial/maximal assistance. When asked what was meant by substantial/maximal assistance, PTA Q reported the use of two-person assistance with either the sit to stand or total mechanical lift, whichever was care planned for use during R18's transfers. Review of the facility policy titled Safe Resident Handling/Transfers, reviewed on 6/15/2023, revealed the following, in part: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines . Resident lifting and transferring will be performed according to the resident's individual plan of care .

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F 0699

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care or services that was trauma informed and/or culturally competent.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41978

Based on interview and record review, the facility failed to ensure completion of trauma assessments and failed to identify behavioral triggers for one Resident (#41) out of one resident reviewed for mood and behaviors with a history of physical abuse, resulting in inaccurate information available to Mental Health professionals and the potential for uninformed and misguided care. Findings include:

All times recorded in Eastern Daylight Time (EDT), unless otherwise noted.

Resident #41 (R41)

R41 was admitted to the facility on [DATE] with a primary diagnosis of dementia with behavioral disturbance.

Review of R41's Minimum Data Set (MDS) assessment, dated 6/9/2024, revealed she had severe cognitive impairment and was assessed as being easily annoyed and short tempered . 12-14 days (nearly every day), during the assessment look back period. The MDS assessment revealed R41 exhibited the following behavior symptoms 1-3 days of the look back period: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing .); verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others); and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, disrobing in public, throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, disruptive sounds).

During an interview on 8/27/2024 at 10:21 a.m., R41's spouse, Family Member (FM) J reported R41 was easily angered, agitated and often lashed out at others out of fear. FM J stated he believed the behavior to stem from a history of severe physical abuse at the hands of R41's former partner. R41 reported the facility was aware of R41's history of abuse and what he believed to be resulting behavioral symptoms. FM J reported R41 may misinterpret hurried activities and sudden movements toward her as aggressive and threatening.

Review of R41's electronic medical record (EMR) from date of admission on 4/17/2023 through 8/27/2024, revealed no documented trauma assessment upon admission or any time after admission for R41.

During an interview on 8/28/24 at 9:21 a.m., Social Services Director, (SW) I reported she was aware of R41's history of abuse. SW I stated she had lengthy discussions with FM J about R41's history but a trauma assessment was never conducted as she was new to the Social Services role. SW I stated she was unaware R41 did not have a trauma assessment upon admission. SW I reported R41 was recently assessed by a Mental Health provider due to increased behavioral symptoms.

A review of R41's Mental Health provider HPI [History of Present Illness], note, dated 7/08/2024, with SW I at the time of the interview, revealed the following:

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per SW [Social Worker] she has been talking to herself more than usual, also not eating well . Histories & Habits . Dementia . Social History Comments: No further med or family [history] available at this time . Psychiatric Social History: Have you experienced any form of abuse: Emotional abuse: No. Physical abuse: No. Sexual abuse: No . History, coordination and Counseling with: Patient, Nursing, Social Worker. Provider exchanged information with above identified persons in order to access, obtain history develop a diagnostic impression and provide treatment recommendations with the goals of facilitating resident-centric integration of care activities having the well being and needs of the resident as the focus. SW I reported R41 had severe cognitive impairment and is a poor historian and most days not able to answer questions in meaningful ways. SW I reported the information regarding R41's history of abuse was important in determining treatment needs and should have been conveyed to the Mental Health provider at the time of the referral. SW I stated since R41's EMR had no documentation of R41's history, this information was not relayed to the Mental Health provider. Review of the facility policy titled, Trauma Informed Care, last reviewed 6/29/2023, revealed the following, in part: The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions . Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35103 Based on observation, interview, and record review, the facility failed to ensure the return or destruction of Resident medications brought in from home and previously opened for nine Residents out of the total facility population of 54 Residents. This deficient practice resulted in the potential for medication diversion, and administration of undated, opened medications with the potential for reduced efficacy and cross-contamination of infectious organisms. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise noted. During an observation on 8/28/24 at 3:21 p.m., four pink bins with individual Resident medication bottles, boxes, patches, tubes, drops, and powders were found in the medication storage room upper wall cabinets. The four pink bins contained the following items: 1st Bin: Five opened, undated, unlabeled tubes of topical medication; one opened, undated bottle of stoma powder; and one opened, undated bottle of antifungal medication. 2nd Bin: Four prescription bottles for R46, including Eliquis (anticoagulant), Lisinopril (antihypertensive), Extra Strength Pain Relief PM (Acetaminophen 500 mg with Diphenhydramine HCL 25 mg), and Metformin (for blood sugar control). 3rd Bin: A seven-day, daily pill [NAME] container marked as Five in a plastic container with unidentified pills. No resident identification was present. 4th Bin: 10 medication bottles, an Omeprazole box, and individually sealed medications that were unlabeled and not inventoried. The Residents identified by the facility for these medications included: R1, R51, R37, R31, R500, R501, R502, and R503. During an interview on 8/28/24 at approximately 3:25 p.m., when asked about the medications found in the unlocked cabinets, Registered Nurse (RN) K stated, They should not be here. They (medications) should have been sent home with the Residents, or they should have been discarded. During an interview on 8/28/24 at approximately 4:16 p.m., the Nursing Home Administrator and Corporate Director of Clinical Services A acknowledged the open, unlabeled and un-inventoried medications should not have been retained for an indeterminate amount of time in the facility medication room. Review of the Medication Storage policy, revised 1/17/24, revealed the following, in part: .Unused Medications: The medication room is routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy. Review of the Destruction of Unused Drugs policy, revised 4/8/24, revealed the following, in part: .Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on interview and record review the facility failed to ensure completion of monthly medication regimen reviews for four Residents (#41, #43, #46 and #9) of five residents reviewed for unnecessary medications, resulting in the potential for administration of unnecessary or inappropriate medications and adverse effects of administered medications. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. Resident #41 (R41) Review of R41's Medication Regimen Review(s),' found in the electronic medical record (EMR) revealed the following: 7/23/2024 at 10:24 p.m. Medication Regimen Review completed. One or more recommendations were made for this resident. To see these and other recommendations please refer to the Director of Nursing [DON] monthly consultation report. Further review of R41's EMR revealed no consultation report indicating what the pharmacist recommendations were, when it was received by the facility and provider, or how and when the facility followed up on the recommendations. R43 Review of R43's Medication Regimen Review(s),' found in the electronic medical record (EMR) revealed the following: 7/23/2024 at 10:23 p.m. Medication Regimen Review completed. One or more recommendations were made for this resident. To see these and other recommendations please refer to the Director of Nursing [DON] monthly consultation report. Further review of R43's EMR revealed no consultation report indicating what the pharmacist recommendations were, when it was received by the facility and provider, or how and when the facility followed up on the recommendations. R47 Review of R47's Medication Regimen Review(s),' found in the electronic medical record (EMR) revealed the following: 7/23/2024 at 10:24 p.m. Medication Regimen Review completed. One or more recommendations were made for this resident. To see these and other recommendations please refer to the Director of Nursing [DON] monthly consultation report. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of R47's EMR revealed no consultation report indicating what the pharmacist recommendations were, when it was received by the facility and provider, or how and when the facility followed up on the recommendations. On 8/27/2024 at 4:30 p.m., a request was made to the DON for the monthly consultation reports for R41, R43 and R47, including facility follow-up to the pharmacist's recommendations, as referenced in the EMR, for R41, R43, and R47 on 7/23/2024. On 8/28/24 at 1:37 p.m. the DON reported she receives the monthly recommendations from the pharmacy, prints the recommendations to present to the providers, who in return follow up with a new order or reason why they did not follow the pharmacy recommendation. The DON stated after the provider reviewed the recommendations the pharmacy reviews are returned to her to follow through with order input and documentation. The pharmacy recommendation forms are then presented to the medical records department for scanning into the respective resident's EMR. The DON confirmed she did not have the requested pharmacy recommendation forms for R41, R43 or R47, as previously requested, and could not account for when the recommendations were received and if follow up was conducted in a timely manner or at all. When asked how the facility ensures monthly medication regimen reviews were completed with appropriate follow-up for all residents, the DON reported she reviews a listing of resident's reviewed on a quarterly (every three month) basis. Review of the facility policy titled, Medication Regimen Review, last reviewed 8/01/2024, revealed the following, in part: Written communications from the pharmacist shall become a permanent part of the resident's medical record. 49735 A review of R9's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: anxiety disorder, depression, dementia, hypertension, and Alzheimer's disease. R9 scored 11 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderately impaired cognition. Review of Electronic Medical Record (EMR) reealed that resident was perscribed Quetiapine fumarate (antipsychotic) and Sertraline (antidepressant). Review of (EMR) did not reveal a monthly Medication Regimen Review (MRR) completed by a licensed pharmacist for January 2024, March 2024, April 2024, June 2024, and July 2024. During an interview on 8/27/24 at 3:52 p.m., the Director of Nursing (DON) acknowledged that she could not find the Medication Regimen Review that was completed by the pharmacist in the EMR for January 2024, March 2024, April 2024, June 2024, and July 2024. Review of facility policy titled Medication Regimen Review date reviewed/revised . 8/1/24, read in part . the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist .the MRR is a thorough evaluation of the medication regiment of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with mediation .the pharmacist shall document either manually or electronically that each medication regimen review has been completed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40383 This citation pertains to intake MI00144174. Based on observation, interview, and record review, the facility failed to ensure palatable meals at satisfactory temperatures were served to four Residents (R42, and three residents in a confidential group interview) of 14 residents sampled for issues related to the dining experience. This deficient practice had the potential to negatively impact Residents' oral intake, weight, and worsen their medical condition. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise specified.) On 8/26/24 at 12:50 PM, the tray line for the lunch meal was underway. The cook (Staff L) was asked for her record of food temperatures. No temperatures were recorded for the lunch she was serving. Staff L said, I didn't record temps. I forgot. Staff L was asked to take the temperatures of the food on the tray line. The meat loaf measured 160 degrees, cauliflower was 152 degrees, potatoes were 129 degrees, carrots were 118 degrees, and the pureed meat was 130 degrees. Staff M stated the holding temperature must not fall below 135 degrees and instructed the cook to take action on the food that was not hot enough. On 8/26/24 at approximately 1:00 PM, the temperature log for the previous dinners were reviewed with Dietary Manager (Staff M). No food temperatures were recorded for 8/21, 8/22, 8/23, 8/24, or 8/25. Staff M stated there have been complaints of cold food in the past. On 8/26/24 at 1:32 PM, Resident 42 (R42) was observed in his room waiting for his meal. R42 stated, The food is usually cold by the time it gets to me. I have nothing else to do but eat it cold. The electronic medical records for R42 were reviewed and revealed a Brief Interview for Mental Status evaluation score of 15 out of 15 indicating intact cognition. The Resident council meeting minutes were reviewed. The 6/12/24 meeting minutes New Business included a quote by one of the residents which read, The food tastes good and much improved, but it is still cold. The facility policy titled Food Safety Requirements dated as reviewed/revised 8/19/24, read in part: Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: . Preparation of food, including thawing, cooking, cooling, holding, and reheating . When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards . Cooking - foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed . Holding - staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2017 Food Code specifies in 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11. 49735 During a confidential group interview on 8/27/24 at 10:00 a.m., CR301 stated I got cold pancakes this morning .the food is always cold. CR303 stated the food is cold. CR304 stated the food is warm but not hot.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49735 Based on interview and record review, the facility failed to accurately report Payroll Based Journal (PBJ) information to CMS (Centers for Medicare and Medicaid Services). This deficient practice resulted in the facility triggering for excessively low weekend staffing with the potential to affect all 54 residents. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted.) Review of the CMS PBJ Staffing Data Report FY (fiscal year) Quarter 2 2024 (January 1- March 31) revealed the metric Excessively Low Weekend Staffing Triggered with Submitted Weekend Staffing is excessively low with infraction dates being : 1/6/24, 1/7/24, 1/13/24, 1/14,24, 1/20/24, 1/21/24, 1/27/24, 1/28/24, 2/3/24, 2/4/24, 2/10/24, 2/11/24, 2/17/24, 2/18/24, 2/24/24, 2/25/24, 3/2/24, 3/3/24, 3/9/24, 3/10,24, 3/16/24, 3/17/24, 3/23/24, 3/24/24, 3/30/24, and 3/31/24. During an interview on 8/28/24 at 12:47 p.m., Business Office Manager/Human Resources G stated, I submit the PBJ information, but the system generates the information .I don't review the data. During an interview on 8/28/24 at approximately 3:15 p.m., the Nursing Home Administrator (NHA) stated, I don't know why we would trigger for low weekend staffing. Review of facility policy titled Payroll Based Journal, provided to this surveyor on 8/28/24 .read in part, It is the policy of this facility to electronically submit .complete and accurate direct care staffing information . the Nursing Home Administrator (NHA), Human Resource Director, and Director of Nursing (DON) are responsible for verifying accuracy of the staffing data that is submitted to CMS using various facility audit forms.

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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 41978 Based on interview and record review, the facility failed to ensure required members of the Quality Assurance and Performance Improvement (QAPI) committee met at least quarterly, resulting in the potential for decreased quality of care for all 54 residents living in the facility. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. Review of the QAPI committee meeting attendance logs with the Nursing Home Administrator (NHA) and the Corporate Director of Clinical Services, Registered Nurse (RN) A on 8/28/2024 at 4:23 p.m., revealed meetings were held on 8/14/2023, 1/30/2024, and 5/01/2024. Further review of the attendance logs revealed the following: 8/14/2023: Medical Director or designee not in attendance. 1/30/2024: Medical Director or designee not in attendance. Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI), last reviewed 4/22/2024, revealed the following, in part: The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan. The QAA Committee shall be interdisciplinary and shall consist at a minimum of: the Director of Nursing Services; the Medical Director or his/her designee; at least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role; and the Infection Preventionist.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on observation, interview, and record review, the facility failed to: 1. Ensure the correct use of personal protective equipment (PPE), 2. Post visual alerts at the entry for staff and visitors regarding information for hand hygiene and source control, and; 3. Post the process for everyone entering the facility of the recommended actions to prevent transmission of COVID-19 in accordance with standards of practice and Centers for Disease Control (CDC) recommendations for COVID-19, during an outbreak. Findings include: On 8/26/24, at approximately 12:30 p.m. the door to the facility's main entrance was observed closed for construction for the pouring of a concrete slab. The door at the end of the 100 unit was being utilized for entering and exiting the facility until construction was completed. On 8/26/24 at 12:30 p.m., Staff B said there was one resident who was positive for COVID-19. Staff B did not know when the resident tested positive or on which unit the resident who tested positive resided. Staff B said everyone who entered the facility was required to wear a mask while in the building. No visual alert was posted at the entry door to convey information regarding the use of source control, personal protective equipment (PPE), or performing hand hygiene. There was no identifiable process, posting, or visual alert to make everyone entering the facility aware of recommended actions or guidance to prevent transmission to others if they had: a positive viral test for SARS-CoV-2 (the coronavirus that causes COVID-19), symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection. There was a table to the left of the entry door containing a box of surgical masks and a box of N-95 masks. No hand sanitizer was available on the table. A hand sanitizer dispenser was located on the wall approximately 12 - 15 feet from the entry door past two residents' rooms. There was no waste receptacle for disposing of masks when exiting the facility. On 8/26/24 at 1:45 p.m. the doors to rooms [ROOM NUMBER] had observed signage posted indicating isolation precautions. The doors to the three rooms were open to the hallway. On 8/26/24 at 3:01 p.m., isolation signage was observed posted on the door to room [ROOM NUMBER]. The doors to the four rooms in isolation were open to the hallway with residents in the hallway outside the doors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Infection Preventionist (IP) said there were five residents who had tested positive for COVID-19. The IP said Resident #36 (R36) tested positive on 8/23/24, and Residents #3 (R3), #43 (R43), #30 (R30), and #18 (R18) had tested positive on 8/26/24. The IP said the residents who had tested positive for COVID-19 all resided on the 200 unit. On 8/27/24 at 7:28 a.m., The 100 hall door being used for entrance and exit from the facility still did not have hand sanitizer, a waste receptacle, directions for the use of PPE or hand hygiene, or postings for recommended actions and guidance for people entering the facility if they experienced a positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection. On 8/27/24 at 8:40 a.m., Certified Nursing Assistant (CNA) C was observed walking up the 200 unit, opened the door at the end of the unit, exited the unit wearing the same mask she was wearing on the affected unit, and did not performing hand hygiene. On 8/27/24 at 8:41 a.m., Staff E was observed entering the building from the door at the end of the 200 unit. Staff E walked the length of the 200 unit without wearing a mask and exited the 200 unit without a mask. Staff E was asked why she was not wearing a mask. Staff E responded, I just walked in. I just got to work. She then exited through another door. Housekeeper F was present and explained, The main entrance is closed right now so staff is using one of the side doors, either on 100 hall or 200 hall. At 8:47 a.m., the Nursing Home Administrator (NHA) reported signage was placed outside the door at the end of 200 hall directing staff to utilize another door. On 8/27/24 at 8:49 a.m., R36, who had tested positive for COVID-19, was observed in his wheelchair on the 200 unit hallway with two other residents within six feet of R36. R36 was coughing openly and repeatedly without covering his mouth. On 8/27/24 at 9:18 a.m., Resident #13 (R13) was observed ambulating in the hallway. CNA D called for CNA C for assistance with R13. CNA C exited room [ROOM NUMBER] wearing gloves she was wearing in room [ROOM NUMBER]. CNA C went into room [ROOM NUMBER] where R13 resided with R36. CNA C obtained a wheelchair and took it to R13. CNA C placed her hand, still donned in the glove she had been wearing in room [ROOM NUMBER], around R13's arm and guided R13 into the wheelchair. CNA C went back into room [ROOM NUMBER] wearing the same pair of gloves and without performing hand hygiene. On 8/27/24 at 9:30 a.m , CNA D was observed through an open doorway assisting R36 in their room with positioning. R36 was openly coughing without covering his mouth. CNA D was not wearing eye protection. An observation was made of CNA D who exited the room, doffed the gown and gloves, and performed hand hygiene but did not remove the N-95 mask used while assisting R36 who was COVID-19 positive. CNA D exited the room and immediately walked down the hall and entered room [ROOM NUMBER] wearing the same mask used in R36's room. The resident in room [ROOM NUMBER] was placed on isolation precautions on 8/28/24 due to the resident showing signs and symptoms of COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/28/24 at 7:39 a.m., the 100 unit door utilized for entry and exit from the facility still did not have a visual posting to convey information regarding the use of source control, personal protective equipment (PPE), or instructions for performing hand hygiene. There remained no identifiable process, posting, or visual alert to make everyone entering the facility aware of recommended actions or guidance to prevent transmission to others if they had: a positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection. The table to the left of the entry door had a box of surgical masks but no hand sanitizer or waste receptacle. The IP was interviewed on 8/28/24 at 8:42 a.m. The IP said staff were to wear gloves, gown, eye protection, and an N-95 mask when they are with residents who tested positive for COVID-19. The IP said only N-95 masks were required when working with residents on the unit who had not tested positive for COVID-19. The IP said surgical masks were being required on the other units in the building. The IP was asked about removing PPE when exiting a room after caring for a resident with COVID-19. The IP said staff should remove all PPE before exiting the room, perform hand hygiene, and put on a new mask immediately upon exiting the room. The IP said it was not permissible to wear the same PPE, including N-95 mask, from the room of a resident with COVID-19 into the hallway or into another resident's room. The IP confirmed staff were not to wear gloves from the care of one resident to another resident. The IP confirmed the facility adheres to CDC recommendations and guidelines to determine infection prevention and control practices and policies. The facility policy Covid Prevention and Response was reviewed with the IP. The policy included the need to post visual alerts regarding source control, recommended PPE, instructions for anyone entering the facility if they had a positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection. The IP said there should have been signage posted but admitted she had not posted anything at the 100-unit door that was being used for entrance and exit from the facility. The Centers for Disease Control (CDC) updated guidelines of 6/24/24 Infection Control Guidance: SARS-CoV-2 at https://www.cdc.gov/covid/hcp/infection-control/index.html, state the following, in part, regarding COVID-19 recommendations: .Ensure everyone is aware of recommended IPC [infection prevention and control] practices in the facility . .Post visual alerts (e.g., signs, posters) at the entrance .these alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene) . .Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria: a positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel) . .Provide guidance (e.g. posted signs at entrances .) about recommended actions for patients and visitors who have any of the above three criteria [a positive viral test for SARS-CoV-2, symptoms of COVID-19, or close contact with someone with SARS-CoV-2 infection] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Iron River Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 330 Lincoln Ave Iron River, MI 49935	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.HCP (Health Care Personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should .use .N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) .