STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235624	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portagepointe	500 Campus Drive Hancock, MI 49930

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to ensure timely monitoring of blood glucose and administration of glucagon (emergency blood glucose elevating medication) for one Resident (R59) of five residents who were prescribed insulin and/or other blood glucose lowering medications. This deficient practice resulted in a delay in treatment for severe hypoglycemia (low blood sugar), and the potential for adverse neurological and physical outcomes for R59. Findings include: Review of R59's Minimum Data Set (MDS) assessment, dated 2/2/24, revealed R59 was admitted to the facility on [DATE] with active diagnoses that included: stroke, end stage renal disease (ESRD), diabetes mellitus, and hemiplegia (paralysis of one side of the body). R59 scored 12 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderate cognitive impairment, with the ability to understand others and be understood by others. Review of R59's care plans revealed the following focus and interventions: Endocrine: The Elder has Diabetes Mellitus type II, date initiated: 2-23-2023 . Report to RN any s/sx (signs/symptoms) of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, etc., date initiated: 2/23/2023. Review of R59's Physician Order Recap Report found no physician prescribed order for the injection of glucagon for treatment of severe hypoglycemia, when R59 was unable to ingest food or drink. Review of LTC (Long-Term Care) Standing Orders - [Facility Name], last revised 1/11/2024, revealed the following, in part: Hypoglycemic Reaction: Follow [Facility Name] Hypoglycemic Protocol. Review of the facility LTC Hypoglycemic Protocol, last revised 3/9/2018, revealed the following, in part: Expected Outcome: Elder's blood sugar will remain in the target goal range. Elder complications from blood sugar changes will be minimized or managed. Assessment: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Check the elder's medical record for their target (goal) blood glucose range. If no target has been established, assume 70 mg/dl (milligrams per deciliter) as the lower threshold of the target . Assess the elder with a change in condition for the following . Severe hypoglycemia: Symptoms may include loss of consciousness, inability to awaken, seizure activity or disoriented behavior with inability to take oral carbohydrate . Interventions: . Treatment of Severe Hypoglycemia: 1. Recognize signs/symptoms of severe hypoglycemia. Check blood glucose via home's monitor and if < (less than) target blood sugar [70 mg/dl] then: - administer 25 gms (grams) of 50% Dextrose intravenously or - administer 1 mg of glucagon via IM (intramuscular) (if unable to obtain venous (IV) access) - notify MD - Check blood glucose 15 minutes after carbohydrate administration - repeat treatment until blood glucose is within target range . Review of R59's progress notes revealed the following, in part: Focus: hypoglycemic (low blood glucose). This evening shift (3/16/24), around 1640 (4:40 p.m.) staff was aware elder (R59) was lethargic and less responsive. This nurse was notified. Elder (R59) briefly opened eyes and closed them, but unable to respond to staff after saying her name loudly and physical stimulation. Elder had secretions in her mouth and throat, audible gurgling, unable to clear secretions, and mouth breathing. VS (vital signs) at 1700 (5:00 p.m.): T (temperature) 97.0, BP (blood pressure) 195/81, P (pulse) 71, O2 (oxygen saturation) 80% RA (on room air), R [respirations 28 (labored)]. HOB (head of bed) elevated. O2 NC 2L (supplemental oxygen applied via nasal cannula at 2 liters). Morphine 0.25 ml (milliliters given) at 1723 (5:23 p.m.). Shallow oral suction with [NAME], unable to hear lung sounds over audible gurgling. BG (Blood Glucose) 23 (severe hypoglycemia) at 1734 (5:34 p.m.) (assessed 54 minutes after finding R59 lethargic and less responsive). Standing order IM glucagon injection at 1740 (5:40 p.m.), elder unable to take anything PO (by mouth). BG 40 at 1751, standing order IM glucagon injection at 1755 (5:55 p.m.). Elder more alert, continues to open eyes briefly, moves head to voice. Doesn't answer yes/no questions, not safe to swallow. Called [Physician H] at 1809 (6:09 p.m.). BG 72 at 1813, he (Physician H) ordered, give another IM glucagon injection and call back with BG update . IM glucagon injection at 1823 . BG 94 at 1840 . During an interview on 5/7/24 at 2:27 p.m., when asked when blood sugar should be assessed when finding a diabetic resident (such as R59) lethargic and unresponsive, Registered Nurse (RN) I said blood sugar should be considered a vital sign and should be assessed with other vitals during a period of decline to determine the cause of the resident's change in condition. RN I said glucagon should be administered promptly after identifying that the blood sugar was low, and the resident was unable to consume foods or beverages (was unresponsive). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the [Hall Name] on 5/8/24 at 7:40 a.m., with RN K found no emergency glucagon in the medication storage cabinet located on the Hall. When asked if any residents may need emergency glucagon, RN K stated, I do have residents who may need glucagon as a standing order. There was none in the cabinet in [different Hall Name] . RN K said she did not know where the glucagon was stored. The Director of Nursing (DON) approached during this interview and reported that there were two emergency glucagon kits in the facility: one each in two of five facility halls. During an interview on 5/8/24 at 8:41 a.m., the DON was asked about the lack of glucagon on all facility halls that housed diabetic residents. The DON stated, We will have them in all of the halls. And I agree with you they should be in all the halls. The DON acknowledged that only two of five halls in the facility had glucagon readily available, and with a resident in the past several months needing three injections of glucagon to raise their blood glucose levels sufficiently, they (emergency glucagon) should be on all the halls and the nursing staff should know where they are located. During a telephone interview on 5/8/24 at 9:27 a.m., RN J confirmed she was providing care to R59 on 3/16/24 when R59 was found lethargic and unresponsive. RN J stated, [R59] was breathing really heavy that day. She was less awake this time. She has had exacerbations of . heart failure - we tried morphine to help with her tachypnea (rapid, labored breathing). It was right at supper time, and it was chaotic. I called the other nurse (on duty on another hall) and she said, 'Did you check her sugar?' I said, 'Oh no, I did not. RN J confirmed R59's blood glucose was 23 mg/dL (milligrams per deciliter) (severe hypoglycemia) when first assessed 54 minutes after being found lethargic and unresponsive. When asked where emergency glucagon was found to administer to R59, RN J stated, I looked in [Hall Name] and there was none (hall were R59 resided) . I called the other nurse, and she ran to [Another Hall Name] and she had two or three of them (emergency glucagon kits). We had three total (that they found in the facility) . We had refill request sheets, and I did one for a couple of emergency glucagon kits for each house. I have never needed to provide glucagon . I did give her three injections. First off, we gave the first one and I was trying to find the policy with all of the details, and I waited another 10-15 minutes checked her sugar it was 43, then I called Physician H, and he gave me the order to give her the third one at a certain time . It took a while to find the glucagon and set it up with the kit . During an interview on 5/7/24 at 1:47 p.m., the Nursing Home Administrator (NHA) was asked if she understood this Surveyor's concern with the delay in blood sugar monitoring and administration of emergency glucagon to raise R59's blood glucose levels after R59 was found lethargic and less responsive. The NHA agreed the delay in assessment and the delay in administration of glucagon to R59, on 3/16/24, after being found with severe hypoglycemia (low blood sugar) was a concern. The NHA stated, I would be concerned if you were not concerned. The NHA said she would expect glucagon be administered within 10 minutes of finding a diabetic resident lethargic and unresponsive.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 49735 Based on interview and record review the facility failed to ensure timely physician response to Medication Regimen Review (MRR) pharmacy recommendations for two Residents (R19 and R52) of five residents reviewed for MRR. This deficient practice has the potential to result in medication irregularities, excessive dosage, side effects, and adverse reactions. Findings include: Resident #19 (R19) A review of R19's Minimum Data Set (MDS) assessment, dated 12/5/23, revealed admission to the facility on [DATE], with active diagnoses that included: progressive neurological conditions, heart failure, hypertension, multiple sclerosis, anxiety, chronic pain, and depression. R19 scored 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. A review of care plan for R19 read in part, . medications sertraline (zoloft) and bupropion (wellbutrin) (psychotropic medications) used simultaneously may increase risk of side effects. A review of R19's monthly MRR by a Registered Pharmacist (RPh) G, dated January 2024, read in part, A Federal Regulation requires Gradual Dose Reduction (GDR) attempts of psychotropic medications in two separate quarters within the first year . RPh G asked the physician to: Please evaluate if a Gradual Dose Reduction can be attempted for R19 at this time. Physician did not sign the MRR until March of 2024. During a phone interview at 10:08 a.m., RPh G said recommendations for MRR are provided to physician for review every month. RPh G provided a Pharmacy Procedure, titled Drug Regimen Review Procedure, to the facility read in part: The pharmacist will complete each of the resident's MRR every month .any irregularities will be available for review by the medical director and must consistently demonstrate a timely and appropriate response from the attending physician. During an interview on 5/8/24 at 10:39 a.m., the Nursing Home Administrator NHA acknowledged the facility did not have a policy for MRR and the Drug Regimen Review Procedure was a Pharmacy procedure given to the DON by the Pharmacist. During the same interview the Director of Nursing DON said, the facility never put a policy together for MRR or timeframe's for physician response regarding MRR. 35103 Resident 52 (R52) A review of R52's MDS assessment, dated 1/30/2024, revealed R52 was admitted to the facility on [DATE], with active diagnoses that included: non-traumatic brain dysfunction, diabetes mellitus, other fracture, Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression. and adjustment disorder with mixed disturbance of emotions and conduct. R52 scored 11 of 15 on the BIMS reflective of moderately impaired cognition. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of R52's monthly MRR prepared by RPh G, dated September 2023, and submitted For Physician Review and Signature, read in part, A Federal Regulation F-758 requires gradual dose reduction attempts of psychotropic medications in two separate quarters within the first year of use and annually thereafter, unless clinically contraindicated. Please evaluate if a gradual dose reduction can be attempted for this elder (R52) at this time. Physician H declined the recommended GDR with a signature dated 11/21/23; approximately 2 months later. Another review of R52's MRR recommendation For Physician Review and Signature, dated December 2023 and prepared by RPh G read in part: Periodic review of full anti-coagulation is recommended for patients without a specified end-date following acute DVT (deep vein thrombosis)/PE (pulmonary embolism) treatment. Elder currently takes xarelto (anticoagulant medication) 20 mg (milligrams) PO (by mouth) Q (every) daily. Her diagnosis list includes acute embolism and thrombosis of unspecified deep veins of right lower extremity (date of event unknown to writer) Please assess if indefinite full anti-coagulation is still indicated. Physician H replied indefinite anticoag (anticoagulation) indicated, signed, and dated 3/1/24; approximately 3 months following RPh G's written recommendation. During an interview on 5/07/24 at 2:40 p.m., when asked if there was a reason for the delay in signing of the pharmacy recommendations for December 2023 and September 2023, Physician H asked to look at the specific documents and stated, I don't know (why there was a delay). I am not in the habit of sitting on those things. He did then state, if they came to my folder here at the long-term care facility, I am here twice a week and I would have signed them. Physician H said if the documents had been sent to his office, that may have resulted in a delay. During a telephone interview on 5/8/24 at 9:58 a.m., the Nursing Home Administrator (NHA) was asked what she considered timely, per the MRR policy, for the physician to address pharmacy recommendations? The NHA said she would expect them addressed by the time the physician next sees them. When asked directly if waiting for two to three months would be considered timely for the physician to sign the pharmacy recommendations, the NHA stated, No that is not timely. The NHA said one month would be considered timely in her estimation. Review of the Drug Regimen Review Procedure, unsigned and undated, revealed the following, in part: . When requested, the attending physician/mid-level practitioner must document in the resident's medical record that an identified irregularity has been reviewed, and what if any action has been taken to address it. The method for notification of irregularities will be determined by the consultant pharmacist and facility, but must consistently demonstrate a timely and appropriate response from the attending physician/mid-level practitioner .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation, interview and record review, the facility failed to 1. Identify and implement corrective action in response to the mechanical dish machine's failure to demonstrate proper sanitizing, 2. Ensure proper air gaps were installed to avoid waste water backflow, 3. Ensure outdated time/temperature controlled food was was not accessible for use, 4. Ensure food trays being prepared for meal service did not become contaminated, 5. Demonstrate proper testing of sanitizing solution for meal preparation conutertops, and 6. Ensure dirty dishes and untensils following meal service were properly stowed in accordance with professional standards for food service safety potentially resulting in food borne illness among any and all 59 residents. Findings include: On [DATE] at approximately 3:00 PM, the three compartment sink in the Medora kitchen was observed to have all three sink compartments draining directly to the sanitary sewer, without an air gap or air break to prevent the back flow of contaminated waste water into the sinks. On [DATE] at approximately 9:00 AM the high temperature under- the- counter dish machine was observed to have the drain line directly connected horizontally to the waste trap T of the adjacent three compartment sink. This direct connection could force waste water into the three compartment sink or allow waste water to gain entrance to the dish machine, un-noticed. The FDA Food Code 2017 states: ,d+[DATE].11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at approximately 8:00 AM, a container of Ham soup base was observed in one of the residential type refrigerators in the Medora kitchen. The soup base container had a facility placed sticker which identified the product to have been received on [DATE]. No expiration date was located. On the bottom of the container was a [NAME] calendar code (0063) which identified the product as having been manufactured on [DATE]. The vendor's product life is known to be 360 days for the product, which would have then expired on [DATE]. An interview with Kitchen Manager (KM) A and Cook B was conducted on [DATE] at approximately 10:30 AM and it was learned the facility did not have a system to address products delivered to the kitchen without expiration dates, by vendors. KM A stated he was not aware of how the [NAME] calendar worked or how the dating system on the bottom of the containers were to be read and expired food identified. The FDA Food Code 2017 states: ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: Pf (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Pf and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf On [DATE] at approximately 12:15 PM, two resident trays were observed on the counter adjacent to the hand sink in the Delaware dining room. As the hand sink was used, water was observed splashing onto the trays which had been set up with beverages and utensils. The FDA Food Code 2017 states: ,d+[DATE].11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE]. On [DATE] at 7:30 AM an interview was conducted with Cook C. It was learned during this interview the facility uses soap and water in the wiping rag buckets, used for wiping counter tops. A spray bottle containing a quaternary ammonium (aka Quat)) sanitizing solution is then used to sanitize the counter tops. On [DATE] at approximately 8:45 AM, an interview was conducted with KM A and Cook B regarding the testing of the Quat solution in the spray bottles. Cook B demonstrated the testing by pouring out a sample from a spray bottle into a small glass. Using test strips QT 40, the strip was dipped into the solution and held for 10 seconds then reported to be in excess of 300 PPM (Parts Per Million). Cook B was requested to measure the temperature of the solution, which was then reported to be 92 F. A review of the package directions for the QT 40 strips, directed the user that the acceptable temperature range for accuracy of the strips was between 65 F and 75 F) KM A and Cook B stated they were not aware of that restriction of the use of the strips. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] between 1:00 PM and 2:00 PM, and following each of the meals on [DATE] and [DATE], soiled resident meal dishes, pans from cooking and other preparation cookware were observed to be piled on the raised counter near the two compartment sink and under-the-counter dish machine in the [NAME] Dining room. These soiled dishes were accessible to residents and guests visiting the facility and the dining room. The FDA Food Code 2017 states: ,d+[DATE].13 Drainboards. Drainboards, UTENSIL racks, or tables large enough to accommodate all soiled and cleaned items that may accumulate during hours of operation shall be provided for necessary UTENSIL holding before cleaning and after SANITIZING.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation, interview and record review, the facility failed to provide an environment which was safe, functional and sanitary for residents, staff and visitors, as evidenced by the failure to provide adequate kitchen facilities for the storage, preparation and delivery of food for all 59 residents. This deficient practice resulted in kitchen space which was not equipped with food service equipment and space to meet minimum standards to provide for the dietary needs of the residents and had the potential to result in negative environmental impacts to residents, employees and visitors due to lack of appropriate ventilation, space and storage needs. Findings include: On 5/6/24 at 1:45 PM then throughout the remaining survey time (5/6/24 to 5/8/24), the dietary facilities were observed to be inadequate and dysfunctional for the storage, preparation and delivery of food. This deficient practice has the potential to affect all 59 residents. Observations included: 1. The main preparation kitchen had been located in an originally designed and constructed [NAME] household kitchen/dining identified by the facility as the Medora household. Food was prepared in this space for all five households of the facility. This kitchen space originally included space for dining, now designated for refrigerator/freezer and mixing equipment. 2. The main kitchen lacked minimum approved equipment, including commercial cooking/baking ovens, refrigeration units, and appropriate storage space in accordance with design standards. Four of the refrigeration/freezer units were non-commercial construction. 3. The small three compartment sink had waste lines directly connected to the sanitary sewer lines, lacking the required air gaps from the rinse and sanitize compartments. 4. The small three compartment sink did not have compartments large enough to handle the large baking and cooking dishes. 5. The preparation kitchen did not have a food preparation sink to allow staff to properly wash produce and other foods needing to be washed prior to service. 6. The under-the-counter dish machine waste line was not installed according to manufacturer's requirements. 7. Counter tops in Medora kitchen had been replaced with non-commercial plastic laminate (Formica) covered tops. 8. The [NAME] dining room kitchen, which had also been designed and constructed as an [NAME] household kitchen was being used for cooking the hot food prior to distributing to the other households. This kitchen did not have adequate space to store soiled dishes from the cooking process as well as the dishes being returned to area required to be washed in the under-counter dish washer. Cooking equipment, returning soiled resident meal dishes and utensils were observed piled on the raised counter, over the two compartment sink facing the dining room where residents ate their meals. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. The two compartment kitchen sink in the [NAME] Dining room was observed to be discolored, stained and pitted, and unable to be cleaned. 10. The [NAME] dining room staff were removing wet dishes from the dish machine and placing them on wheeled carts, located over a carpeted area making it wet and unable to be properly cleaned. 11. The interior of the sink base cabinet for the two compartment sink in the [NAME] dining room was deteriorating and in poor condition. 12. The facility had placed temporary vertical fabric covered barriers in the [NAME] dining room to segregate the area used to drain and dry wet dishes on the racks and the dining room area. This removed approximately 120 square feet (10' x 12') of useable dining room space. These temporary barriers had been in place since July 2023. 13. The dish machine in the [NAME] Dining room was observed to be leaking onto the floor when operating and opened following a cycle of use. An interview with Cook C on 5/7/24 at approximately 9:15 AM confirmed this condition had been an ongoing problem for months. 14. The kitchen was not provided with a designated housekeeping closet, including a mop sink, mop storage area and cleaning chemical storage. On 5/8/24 at approximately 10:20 AM, an interview was conducted with Cook C concerning the functionality of the space and equipment in the [NAME] kitchen/dining room. Cook C stated the ovens don't always work correctly, making it difficult to properly heat food, and though, food preparation was conducted in the Medora kitchen, all cooking, for the entire population of residents occurred in the two small non-commercial style ovens. Cook C also stated there was not adequate space to store the soiled dishes coming back from the residents' meals. Cook C continued that the small under counter dish machine leaked water onto the floor regularly, and staff were required to conduct all dish washing activities for cooking equipment and residents' soiled dishes in the machine. Cook C also shared that there was not an acceptable location to place racks of wet dishes after being removed from the dish machine. Cook C stated placing the wet trays on the wheeled carts behind a temporary make-shift wall, and allowing them to drip and dry over carpeting, deemed inappropriate. These same sentiments were shared by Kitchen Manager A and the Nursing Home Administrator. On 5/6/24 at approximately 2:30 PM an interview with the Nursing Home Administrator (NHA) was conducted concerning the kitchen facilities. The NHA confirmed the facility had agreed to the commencement of the construction of new kitchen facilities, following the previous year's survey. The NHA confirmed that contracts had not been signed or any construction begun to correct the same issues as identified during the previous survey and documented on the current survey.