STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER: Jamieson Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 790 S US Hwy 23, Box 369 Harrisville, MI 48740	

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview and record review, the facility failed to regularly assess the nutritional needs and follow the physician's diet order for two Residents (#11 & #18) of three residents reviewed for nutritional needs. This deficient practice resulted in the potential for nutritional compromise, undetected physical decline, and weight loss. Findings include: Resident #11 (R11) The medical record for R11 revealed an admitted [DATE]. Current diagnoses for R11 included: dementia, anxiety, depression, history of stroke, and history of traumatic brain injury. During meal rounds on 1/21/25 at 1:35 PM, R11 was observed in the dining room eating a pureed consistency lunch. She consumed 100% of her meal. The tray card read Regular Diet, Regular Texture although she was served a puree consistency diet. The tray card also included: Dislikes: .Split Pea Soup . R11 received pureed split pea soup. The medical chart for R11 revealed an active care plan which included, (R11) is at risk for nutritional deficits r/t (related to) many diagnoses that may affect nutrition unspecified dementia without behavioral disturbances, HTN (hypertension), major depressive disorder, GERD (gastroesophageal reflux disease) . traumatic brain injury . anxiety disorder, weakness . Date initiated: 01/31/2023. Interventions for this care plan focus included: .Provide and serve diet as ordered. (R11) has pureed diet, regular fluids, uses covered cup. Revision on 1/7/2025. While the care plan revealed a puree diet was planned, the physician diet order read: REGULAR CONSISTENCY, REGULAR DIET, THIN LIQUIDS dated 12/01/2021. This order was reviewed and signed as approved by Medical Director (MD) G on 1/8/25. (Handwritten telephone orders were present in the medical record from 12/1/24 which read pureed diet and were signed by Medical Director (MD) G on 12/1/24 but had not been carried forward to the January 2025 orders.) The medical chart for R11 also included quarterly and annual nutritional assessments dated 12/13/23, 3/4/24, and 12/31/24. The 12/13/23 annual nutritional assessment concluded R11 had a normal nutritional status with a score of 13. The 3/4/24 quarterly nutritional assessment concluded R11 had a normal nutritional status with a score of 14. The 12/31/24 quarterly nutritional assessment had changed and concluded R11 was At risk of malnutrition with a score of 8.0. There were no quarterly nutritional assessments between the 3/4/24 and 12/31/24 assessments. The nutritional status had the potential to be identified earlier if the missing assessments were completed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 2:15 PM, Certified Dietary Manager (CDM) A was asked what actions were taken with this decline in nutritional status. With the missing nutritional assessments, she was not certain when the decline occurred and said, I must have missed a few (assessments). CDM A said with a decline in condition she would contact the consulting Registered Dietitian (RD) H. There was no documentation of RD H being alerted following the 12/31/24 assessment which identified R11 was At risk of malnutrition. Resident #18 (R18) The medical record for R18 revealed an admitted [DATE]. Current diagnoses for R18 included: kidney disease, depression, diabetes, dementia, and anxiety. During meal rounds on 1/21/25 at 1:00 PM, R18 was observed being fed lunch by Certified Nurse Aide (CNA) F. CNA F reported R18 usually accepted most of her pureed food but did not always take the fluids as well. R18's tray card read Regular Diet, Regular Texture although she was served a puree consistency diet. The medical chart of R18 was reviewed. The care plan for R18 included, Care plan: (R18) is at risk for nutritional deficits r/t many diagnoses that may affect nutrition (elevated blood pressure . chronic kidney disease [CKD] with stage 1 through stage 4 CKD, major depressive disorder, palpitations, DMII w/o (Diabetes type 2 without) complications . Interventions for this care plan focus included: .Provide and serve diet as ordered. Regular diet, regular texture, regular fluids, thin consistency . While the meal served was a puree diet, the physician diet order read: REGULAR dated 1/4/2023. This order was reviewed and signed as approved by Medical Director (MD) G on 1/9/25. (Handwritten telephone orders were present in the medical record from 12/1/24 which read pureed diet carnation instant breakfast drink (CIB) 4 oz [ounces] and were signed by Medical Director (MD) G on 12/1/24 but had not been carried forward to the January 2025 orders and had not been included in the care plan.) The medical chart for R18 included quarterly and annual nutritional assessments dated 1/7/24, 4/8/24, and 7/7/24. The 1/7/24 nutritional assessment concluded R18 was At risk of malnutrition with a score of 11. The 4/8/24 nutritional assessment concluded R18 was At risk of malnutrition with a score of 11. The 7/7/24 nutritional assessment concluded was At risk of malnutrition with a score of 10. There were no further quarterly or annual nutrition assessments after 7/7/24. This 7/7/24 last nutritional assessment completed by the CDM recorded a weight of 90.2 pounds. R18's most current weight was 86.1 pounds recorded in January 2025. During an interview on 1/23/25 at 2:33 PM, CDM A was asked about the missing assessments for R18 and replied, I am behind on that. I guess I missed two assessments. She (R18) has always been nutrition at risk. The consultant RD H progress note dated 12/13/2024 read in part: Note Text: Resident currently receives a regular diet, regular texture, regular fluids, thin consistency. It should be noted the handwritten telephone order of 12/1/24 had changed the diet to puree consistency. The consultant RD H progress note dated 12/17/2024 read: Note Text: Per discussion with CDM at facility visit CIB was added TID (three times daily) and diet cahnged (sic) to pureed in attempt to increase intake and weight. Will review as needed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45123 Based on interview and record review, the facility failed to provide rationale on pharmacy medication regimen review (MRR) recommendations being declined by the physician for two Residents (#6 and #11) of five residents reviewed for MRR's. Findings include: Resident #11 (R11) Review of R11's medical record revealed an admitted [DATE] with diagnoses including dementia, depression, and anxiety. A review of the 12/31/24 Minimum Data Set (MDS) assessment revealed a score of 3 on the Brief Interview for Mental Status (BIMS) assessment indicative of severely impaired cognition. Review of R11's pharmacy recommendation, dated 11/26/24, read in part, Comment: [R11] has a PRN (as needed) order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg (milligrams), give 1 tablet by mouth twice daily as needed. Recommendation: Please discontinue PRN Lorazepam .If the medication cannot be discontinued at this time, please document the indication for use, the intended duration of therapy, and the rationale for the extended time period . R11's MRR dated 11/26/24 was signed by Medical Director (MD) G on 12/4/24 and marked decline to discontinue the medication without providing a rationale for continuation of use. 40383 Resident #6 (R6) Review of R6's medical record revealed an admitted [DATE] with diagnoses including depression, anxiety and diabetes. The current physician's orders dated 1/8/25 read: BLOOD SUGAR VIA FINGERSTICK (a short needle used to draw blood) VIA METER THREE TIMES DAILY ., GLIMEPIRIDE 4 MG (milligram) tablet Give 1 tablet by mouth twice daily with food A review of R6's pharmacy consultant report recommendations dated 10/22/24, read in part, - Comment: (R6) receives a sulfonylurea Glimepiride. Recommendation: Please discontinue Glimepiride. If appropriate, adjust the diabetes regimen by increasing Levemir. - Rationale for Recommendation: Sulfonylurea's should be avoided in older adults due to the risk of cardiovascular events and prolonged hypoglycemia . - Physician Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: The Medical Director (MD) G did not provide a rationale and signed the consultation report on 11/6/24. A review of R6's pharmacy consultant report recommendations dated 12/18/24, read in part, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Comment: (R6) receives insulin and a sulfonylurea, Glimepiride concomitantly, increasing the risk of hypoglycemia. - Recommendation: Please discontinue Glimepiride. - Physician Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: The Medical Director (MD) G did not provide a rationale and signed the consultation report on 1/8/25. A review of R6's pharmacy consultant report recommendations dated 12/18/24, read in part, - Comment: (R6) frequently requires insulin per sliding scale . - Recommendation: Please decrease sliding scale insulin to BID (twice per day) with the end goal of discontinuing sliding scale while adjusting the diabetes regime by increasing Levemir to 67 u (units) BID. Close monitoring (e.g. glucose) should accompany any change in diabetic therapy and guide further adjustments. - Rationale for Recommendation: Prolonged use of sliding scale insulin is not recommended as it often results in wide variations in blood glucose, including prolonged periods of hyperglycemia or hypoglycemia. - Physician's Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: The Medical Director (MD) G did not provide a rationale and signed the consultation report on 1/8/25. During an interview on 1/23/25 at 12:26 PM, the DON stated, I have addressed this issue with this physician in the past and will have to do it again. Review of the Quality Assurance (QA) Committee policy, undated, read in part, .The QA committee shall include the following components for quarterly review .Pharmaceutical Services: Safe and effective drug therapy. Medication records will be reviewed monthly by the Registered Pharmacist for safety and effectiveness of the prescribed regimen. Problems will be referred to the attending physician. The DON will also review PO (oral) and medication records for UN necessary (sic) drugs, appropriate diagnosis for drug use, appropriate administration and side effects . Review of policy titled Antipsychotic Medication Use, revised April 2007, read in part, Policy Statement: Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on interview and record review, the facility failed to indicate a specific duration (end date) for PRN (as needed) psychotropic (drug that affects brain activity) medication, provide gradual dose reductions for psychotropic medications and include non-pharmacological interventions when psychotropic medications were prescribed for three Residents (#6, #11, and #12) of five residents reviewed for unnecessary medications. Findings include: Resident #11 (R11) Review of R11's medical record revealed an admitted [DATE] with diagnoses including dementia, depression, and anxiety. A review of the 12/31/24 Minimum Data Set (MDS) assessment revealed a score of 3 on the Brief Interview for Mental Status (BIMS) assessment indicating severely impaired cognition. Review of R11's, physician orders, dated January 2025, revealed a signature from the physician on 1/8/25 and an order dated 11/4/24 for Lorazepam 0.5 mg tablet, give 1 tablet by mouth twice daily as needed. No indication for use or end date for PRN Lorazepam was present on the physician orders. Review of R11's care plan, date revised 1/7/25, read in part, .Focus: [R11] has a behavior problem anxiety r/t (related to) dementia. Goal: [R11] will have fewer episodes of anxiety by review date .Interventions: Administer medications as ordered. Monitor/document side effects and effectiveness . R11's care plan lacked any non-pharmacological interventions for their anxiety. Review of R11's pharmacy recommendation, dated 11/26/24, read in part, Comment: [R11] has a PRN (as needed) order for an anxiolytic, which has been in place for greater than 14 days without a stop date: Lorazepam 0.5 mg (milligrams), give 1 tablet by mouth twice daily as needed. Recommendation: Please discontinue PRN Lorazepam .If the medication cannot be discontinued at this time, please document the indication for use, the intended duration of therapy, and the rationale for the extended time period . R11's MRR dated 11/26/24 was signed by the Medical Director (MD) G on 12/4/24 and it was marked decline recommendation without providing a rationale for continuation of this as needed medication. On 1/23/25 at 12:15 PM, a review of R11's medical record and physician progress notes, dated September 2024 through January 2025, revealed the lack of monitoring for the effectiveness and continued use of the PRN Lorazepam. On 1/24/25 at 11:00 AM, an interview was conducted with the Director of Nursing (DON), who was asked why R11 was prescribed the as needed Lorazepam and replied, (R11) was going through an adjustment period. The DON was asked why there was not an end date to the medication and replied, I am not sure, but there should have been an end date. The DON was asked if there was any follow-up from the physician on the use of the Lorazepam. The DON then reviewed R11's medical record and replied, I do not see any follow-up. Resident #12 (R12) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R12's medical record revealed an admitted [DATE] with diagnoses including depression and Parkinson's disease (a disorder of the central nervous system that affects movement). A review of the 12/20/24 MDS assessment revealed they scored 11 on the BIMS assessment indicating moderately impaired cognition. Review of R12's, physician orders, dated January 2025, revealed an order for citalopram 10 mg, give one tab daily. Review of R12's, MRR's dated July through December 2024, revealed R12 last had a gradual dose reduction (GDR) attempt on 9/6/23 and was due for another GDR on 9/17/24, but was not attempted. Review of R12's physician progress notes, dated September 2024 through January 2025, lacked any documentation regarding R12's citalopram depression medication. There was no evidence of a GDR attempt or rationale for clinical contraindication for not performing a GDR. On 1/24/25 at 11:00 AM, an interview was conducted with the DON, who was asked if R12 had any documentation of an attempt or clinical rationale for not performing a GDR in September 2024. The DON replied, I am not sure about a GDR or an explanation. I do not have any documentation that a GDR was attempted in September. Review of R12's care plan, date revised 1/7/25, read in part, .Focus: [R12] uses antidepressant medication r/t (related to) depression. Goal: [R12] will be free from discomfort or adverse reactions related to antidepressant therapy through the review date .Interventions: Administer antidepressant medication as ordered by physician. Monitor/document side effect and effectiveness Q (every) shift . R12's care plan lacked any non-pharmacological interventions for their depression. 40383 Resident #6 (R6) Review of R6's medical record revealed an admitted [DATE] with diagnoses including depression, and anxiety. The current physician's orders dated as approved by the attending physician on 1/8/25 included: Duloxetine HCL (hydrochloride) 60 MG capsule Give on capsule by mouth once daily (a medication used to treat depression). The care plan for R6 included a focus of: (R6) uses antidepressant medication Cymbalta r/t (related to) Depression. Date Initiated: 07/01/2023 Revision on: 08/20/2023 The only intervention for this focus was listed as, Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. Date Initiated: 07/01/23. No behavioral interventions were included. The care plan for R6 included a focus of: (R6) has a mood problem r/t Use/side effects of medication. Date Initiated: 07/01/2023 Revision on: 08/20/2023. The only intervention for this focus was listed as, Administer medications as ordered. Monitor/document side effects and effectiveness. Date Initiated: 07/01/23. No behavioral interventions were included. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 2:00 PM, the DON reviewed the care plan for R6 and indicated she could not find non-pharmacological interventions. The medical chart also included a daily BEHAVIOR/MOOD SYMPTOM TRACKING TOOL. It was noted for the January 2025 tracking, the tool included a column to document interventions for behaviors. For all days in January no behavioral interventions were listed. Review of the Quality Assurance (QA) Committee policy, undated, read in part, .The QA committee shall include the following components for quarterly review .Pharmaceutical Services: Safe and effective drug therapy. Medication records will be reviewed monthly by the Registered Pharmacist for safety and effectiveness of the prescribed regimen. Problems will be referred to the attending physician. The DON will also review PO (oral) and medication records for UN necessary (sic) drugs, appropriate diagnosis for drug use, appropriate administration and side effects . Review of policy titled Antipsychotic Medication Use, revised April 2007, read in part, Policy Statement: Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition. Policy Interpretation and Implementation .9. For acute psychiatric situations, antipsychotic medication use shall meet the following criteria: a. The acute treatment period is limited to seven days or less; and b. A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days, to identify and address any contributing and underlying causes of the acute psychiatric condition and verify the continuing need for antipsychotic medication; and c. Pertinent non-pharmacological interventions must be attempted .15. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences Facility requirements for antipsychotic use: 1. All physicians review and make note on effectiveness at each rounds visit .6. Annual gradual dose reduction or risk vs benefit statement for continued use.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40383 Based on observation, interview, and record review the facility failed to serve the correct portions as planned on the menu. This deficient practice had the potential to negatively affect the nutritional status of all 18 residents residing in the facility. Findings include: During an observation in the dietary department on 1/21/25 at 12:48 PM, Certified Dietary Manager (CDM) A was serving lunch of split pea soup, ham salad sandwich, mixed fruited jello and beverage of choice. The following portion sizes were served: - Regular diet: 4 oz (ounces) split pea soup, 1/2 ham salad sandwich, - Puree diet: 2 oz split pea soup, 2 oz pureed ham salad bread mixture The planned menu was reviewed and revealed: - Regular diet: 8 oz split pea soup, 1/2 ham salad sandwich, - Puree diet: 4 oz (#8 scoop) split pea soup, 2 oz (#16 scoop) pureed ham salad bread mixture During an observation of lunch service on 1/22/25 at 12:30 PM in the dietary department, the following portion sizes of hot pork sandwich (pork over a slice of bread with gravy) mashed potatoes, mixed vegetables, and pears were served: - Regular diet: 2 oz pork on one slice of bread, 4 oz (1/2 cup) mashed potatoes/gravy, 4 oz (1/2 c) mixed vegetables - Puree diet: 2 oz. pork (pureed with bread), 2 oz mixed vegetables, 2.67 oz (#12 scoop) mashed potatoes The planned menu was reviewed and revealed: - Regular diet: 2 oz pork on slice of bread, 4 oz mashed potatoes/gravy, 4 oz mixed veg. (vegetables) - Puree diet: 4 oz (#8 scoop) pureed pork blended with bread, 4 oz pureed mixed vegetables, 4 oz mashed potatoes. The puree consistency diet received only half of the food that was planned on the menu. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The menus were discussed at 2:05 PM on 1/22/25. CDM A stated a #8 scoop (or 4 oz) portions for each item on the puree diet would be too much. The evening meal was reviewed for 1/22/25, it planned the regular diet receive 8 oz of goulash, while the puree diets receive a #16 scoop (2 oz). The diet plan was not the same portion for each consistency. During a telephone interview on 1/22/25 at 1:46 PM, the Registered Dietitian (RD) H stated those residents receiving a pureed diet should receive the same portions as those with a regular consistency. The recipes were requested for the ham salad sandwich and the split pea soup. Neither recipe gave portion sizes or nutritional break downs. The ham salad sandwich recipe did not indicate the steps, ingredients, or amounts needed to produce a puree portion.

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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. 40383 Based on observation, interview, and record review, the facility failed to monitor operation of the dish machine to assure dishes, utensils, and other food preparation equipment were properly sanitized. This deficient practice had the potential to promote food borne illness amongst any or all of the facility population of 18 Residents. Findings include: On 1/22/25 at 1:00 PM, the kitchen staff were observed operating the chlorine based cold temperature dish machine. (This was a chemical sanitizing dish machine which used chlorine rather than hot water plus chemicals in the ware washing process.) Certified Dietary Manager (CDM) A was asked to measure the chemical sanitizer dispensing in the machine. A quaternary strip was used (which cannot measure chlorine present to sanitize the dishes or food preparation equipment being washed in the dish machine). When the strips were examined and determined to be unable to measure the sanitizer, the kitchen staff found one roll of chlorine strips in a bag labeled expires 2/14/24. The dish machine was retested and while the strip turned dark, there was not a comparison color chart to accurately compare and determine the level of chlorine the dish machine had dispensed. The amount of sanitizer could not be accurately determined. CDM A noted the kitchen staff had been recording the sanitizer level on the dish machine logs, but stated they had been using the wrong strips since the interim CDM had left last April. The FDA Food Code 2017 states: 4-703.11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: . (C) Chemical manual or mechanical operations, including the application of SANITIZING chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under S 4-501.114. Contact times shall be consistent with those on EPA-registered label use instructions by providing: (1) Except as specified under Subparagraph (C)(2) of this section, a contact time of at least 10 seconds for a chlorine solution specified under 4-501.114(A), P (2) A contact time of at least 7 seconds for a chlorine solution of 50 MG/L (liter) that has a PH of 10 or less and a temperature of at least 38oC (100oF) or a PH of 8 or less and a temperature of at least 24oC (75oF) .

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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 45123

Based on observation, interview, and record review, the facility failed to implement and develop an enhanced barrier precautions (EBP) policy, and update infection control policies annually based on standards of practice. This deficient practice has the potential to affect all residents regarding infection control practices. Findings include:

On 1/21/25 at 11:00 AM, during the entrance conference, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were asked to provide the infection control program policies for the facility.

Resident 14 (R14)

Review of R14's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment of 15, indicative of intact cognition.

Review of R14's care plan, date revised 12/28/24, read in part, .Focus: [R14] has a catheter: Neurogenic bladder. Goal: [R14] will remain free from catheter-related trauma .Interventions: Check tubing for kinks 1 x and prn (as needed) each shift. Monitor and document intake and output as per facility policy. Cath (catheter) will be changed monthly . R14's care plan lacked any initiation for EBP as indicated by the Centers for Disease Control (CDC) while performing catheter care, which is listed as a high contact care activity involving a medical device.

On 1/21/25 at 12:30 PM, an observation was made of R14's room which lacked any Personal Protective Equipment (PPE) cart or EBP sign on the door indicating precautions were necessary to perform high contact direct care activities, such as catheter care.

During an interview on 1/22/25 at 2:10 PM, R14 declined the opportunity for this Surveyor to observe catheter care. R14 was asked if facility staff wear any kinds of PPE and replied, They wear gloves. R14 was asked if facility staff wear a gown when performing catheter care and replied, No, just gloves.

On 1/22/25 at 2:20 PM, an interview was conducted with Certified Nurse Aide (CNA) F, who was asked what PPE was used to perform catheter care for R14 and replied, I wear gloves and put a barrier down on the floor. I use alcohol swabs and a hat to collect the urine. CNA F confirmed no other PPE was used when providing catheter care.

On 1/22/25 at 3:00 PM, a review of all the infection control policies was completed. The following infection control policies had not been updated annually per standards of practice:

a. Covid-19 Vaccination policy last updated on 12/1/20;

b. Influenza Vaccination policy undated and no revision;

c. Pneumococcal Vaccination policy undated and no revision;

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Jamieson Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 790 S US Hwy 23, Box 369 Harrisville, MI 48740	

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	d. Isolation - Initiating Transmission-Based Precautions last updated on 12/2007; and e. Surveillance/Antibiotic Stewardship policy undated and no revision. On 1/23/25 at 10:35 AM, an interview was conducted with the NHA, who was asked if she knew how often infection control policies were reviewed and updated and replied, I don't know, you would have to go ask the DON. On 1/23/25 at 10:45 AM, an interview was conducted with the DON, who was asked if she knew how often infection control policies were reviewed and updated and replied, Well yearly. We look at them in quality assurance (QA) and I have a sign off sheet in the infection control book that they were reviewed. The DON was asked to provide the sign off sheet that all the infection control policies were reviewed annually. The DON was also asked if the facility had a policy for EBP and if they had implemented EBP per CDC guidance. The DON replied, No, we do not have a policy for EBP. I did not know that a new implementation with infection control was out for EBP. The DON was unable to provide the sign off sheet by the time of exiting the survey. Review of the Quality Assurance policy, undated, read in part, Policy Statement: It is the policy of this facility to develop, implement, and maintain an ongoing program designated to monitoring and evaluate the quality of resident care, pursue methods to improve quality care, and to resolve identified problems .2. To establish and provide a system whereby a specific process, and the documentation relative to it, is maintained to support evidence of an ongoing Quality Assessment and Assurance Program, encompassing all aspects of resident care including safety, infection control .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jamieson Nursing Home	790 S US Hwy 23, Box 369 Harrisville, MI 48740

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 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that paid feeding assistants have the training they need. 40383 Based on observation, interview and record review the facility failed to train non-licensed employees with the State-approved training course for feeding assistance to residents. This deficient practice put vulnerable residents at risk of complications associated with being fed for all residents needing feeding assistance (approximately six residents). Findings include: During the breakfast observation in the dining room on 1/22/25 at 8:34 AM, Certified Dietary Manager (CDM) A was observed feeding Resident #4 (R4) a pureed diet. When asked why she was feeding R4, CDM A said assistance was needed as other staff were not available. When asked about the risk involved, CDM replied that all residents on a pureed diet were at risk for choking. CDM A stated, Occasionally they ask me to help out and feed . When asked if she had taken the State-approved training program for feeding assistants, CDM A said the DON (Director of Nursing) gave me a refresher when I started 3 maybe 4 years ago. During an interview on 1/22/25 at 10:35 AM, the DON stated, I taught (CDM A), not a class - just common-sense stuff . (CDM A) used to be a CNA (Certified Nurse Aide) and is a CDM now. I don't know if she has kept up her license . We were short staffed this morning. The DON did not have record of CDM A taking the State-approved training course for paid feeding assistants including, at a minimum, 8 hours of training in: feeding techniques, assistance with feeding and hydration, communication and interpersonal skills, appropriate responses to resident behavior, safety and emergency procedures, including the Heimlich maneuver, infection control, resident rights, and recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. The DON stated she was not familiar with the State-approved training course. The facility provided a paper that read in its entirety: Procedure for feeding resident a pureed diet: Sit the resident up straight, give them time to swallow between bites, and offer liquids between every few bites. The page was signed by the Nursing Home Administrator (NHA) and was undated as to initiation date or review date. The facility also provided a paper that read in its entirety: Kitchen Staff Feeding Policy: DON can train kitchen staff to feed puree residents. If Kitchen staff is needed to help feed residents the DON should instruct them on the proper procedures in feeding Residents both puree and regular diets. The page was signed by the NHA and was undated as to initiation date or review date.