| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235635 | A. Building<br>B. Wing | 07/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caretel Inns of Tri-Cities | 6700 Westside Saginaw Road<br>Bay City, MI 48706 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944<br><br>Based on observation, interview and record review the facility failed to implement a baseline care plan for oxygen administration for one resident (Resident #261) of one resident reviewed for oxygen administration resulting in the lack of a care plan for oxygen and unmet care needs.<br><br>Findings include:<br><br>Resident #261 (R261):<br><br>Resident #261 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, heart failure and emphysema.<br><br>On 07/15/24 at 10:50 AM, observation revealed R261 was on oxygen and the tubing on the oxygen concentrator was not labeled with a date of the last time it was changed.<br><br>On 07/16/24 at 01:12 PM, observation revealed that the oxygen tubing for R261 is not labeled and dated.<br><br>On 07/16/24 03:46 PM, record review revealed a physician's order for oxygen administration via nasal cannula at a flow rate of 2 liters per minute, the order was dated 07/09/24.<br><br>On 07/16/24 at 03:44 PM, record review revealed there was no care plan present in the electronic health record (EHR) for oxygen use and equipment management.<br><br>On 07/16/24 at 03:53 PM, an interview was conducted with LPN G, LPN G was asked if there should be a date and label on the oxygen tubing and if the resident should have a care plan in place for the use of oxygen. LPN G stated yes they should have both and that they would change the tubing and label it right now. LPN G stated they would enter a care plan as well for R261.<br><br>On 07/17/24 at 10:22 AM, the Director of Nursing (DON) was made aware that there was no care plan present for R261's oxygen use. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944<br><br>Based on observation, interview and record review, the facility failed to label oxygen tubing with the date it was changed for one resident (Resident #261) of one resident reviewed for oxygen administration resulting in tubing that was not labeled and the likelihood for infection.<br><br>Findings include:<br><br>Resident #261 (R261):<br><br>Resident #261 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, heart failure and emphysema.<br><br>On 07/15/24 at 10:50 AM, observation revealed R261 was on oxygen and the tubing on the oxygen concentrator was not labeled with a date of the last time it was changed.<br><br>On 07/16/24 at 01:12 PM, observation revealed that the oxygen tubing for R261 is not labeled and dated.<br><br>On 07/16/24 at 01:13 PM, record review of the July 2024 medication administration record (MAR) revealed that a staff member signed out that R261 had their oxygen tubing changed on 07/14/24. R261 has a physician order to change the oxygen tubing weekly every Sunday on the night shift(PM).<br><br>On 07/16/24 03:46 PM, record review revealed a physician's order for oxygen administration via nasal cannula at a flow rate of 2 liters per minute, the order was dated 07/09/24.<br><br>On 07/16/24 at 03:53 PM, an interview was conducted with LPN G, LPN G was asked if there should be a date and label on the oxygen tubing and if the resident should have a care plan in place for the use of oxygen. LPN G stated yes they should have both and that they would change the tubing and label it right now. LPN G stated they would enter a care plan as well for R261.<br><br>On 07/17/24 at 10:22 AM, the Director of Nursing (DON) was made aware that there was no label or date on the oxygen tubing for R261.<br><br>A review of the policy titled Oxygen Administration, created 7/2022 revealed:<br><br>Infection control issues:<br><br>2. The oxygen delivery device (e.g., nasal cannula, mask) will be changed once a week or as needed. The tubing will be dated to assist with tracking of when the tubing should be changed. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>22347<br><br>Based on observation, interview and record review, the facility failed to ensure that 3 of 3 medication carts were neat and clean (100 Hall, 200 Hall, & 300 Hall), and ensure that no medications were left at the bedside of one resident (Resident #2). resulting in medication not being taken, checking on medications, non-sanitary medication carts, lost or not counted medications and the likelihood for contamination.<br><br>Findings Include:<br><br>During an observation made on 7/15/24 at 11:14 a.m., accompanied by Nurse, LPN M the following was found:<br><br>Medication Cart 300:<br><br>-The large second drawer was found to have crushed pills and papers in the bottom.<br><br>-The Third and fourth drawers were found to be dirty with dust, papers, crushed pills and dried liquids on the bottom of the drawers.<br><br>During an interview done on 7/15/24 at 11:18 a.m., Nurse M stated It is second shifts job to clean it (the medication carts).<br><br>During an observation made on 7/15/24 at 11:56 a.m., accompanied by Nurse, LPN G the following was found:<br><br>Medication Cart 300:<br><br>-The second, third and fourth drawers had an extensive amount of crushed pills, papers on the bottom of them.<br><br>-The second drawer had 1 small round blue pill, a small green pill and a white capsule loosely on the bottom of the drawer.<br><br>During an interview done on 7/15/24 at 11:57 a.m., Nurse G stated I am agency, I don't know who cleans them (medication carts); ya, they are dirty.<br><br>During an interview done on 7/16/24 at 12:30 p.m., the Director oaf Nursing/DON stated The night shift nurses clean the carts.<br><br>During an observation medication pass done on 7/17/24 at 8:13 a.m., medication cart for Hall 100, was found to have x 8 loose pills between the metal lock box and the cart itself. The pills were visible from the top as you look down at the narrow space between the box and the cart on the left side.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility Medication Storage in the Facility policy (un-dated), stated Medication storage conditions are monitored on a regular basis by the facility and pharmacy and corrective action taken if problems are identified.<br><br>Review of the facility Night Shift Duty Sheet (un-dated), stated Clean & Stock med carts.<br><br>Review of the facility (name of pharmacy) Pharmacy Medication sheet dated 6/26/24, revealed no observation or documentation of how the medication carts were maintained (clean and well organized). |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050<br><br>Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment affecting 50 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality.<br><br>Findings include:<br><br>On 07/15/24 at 10:12 A.M., An initial tour of the food service was conducted with [NAME] - Executive Chef I. The following items were noted:<br><br>The Coffee Machine (interior and exterior) was observed soiled with accumulated and encrusted food residue. The two dispensing spouts were also observed soiled with accumulated and encrusted mineral (lime and calcium) deposits. Executive Chef I indicated he would have staff thoroughly clean and sanitize the coffee machine as soon as possible.<br><br>The avocado green Osterizer blender was observed soiled with accumulated and encrusted food residue. The blender selection buttons and spaces between were observed heavily soiled with accumulated and encrusted food residue.<br><br>The Panasonic microwave oven exterior top surface was observed with accumulated adhesive residue. The adhesive residue area measured approximately 4-inches-wide by 8-inches long. Executive Chef I indicated he would have staff thoroughly clean and sanitize the microwave oven exterior surfaces as soon as possible.<br><br>The meat slicer was observed soiled with accumulated and encrusted food residue. The protective nylon meshed bag covering the meat slicer was further observed heavily soiled and sticky with accumulated and encrusted food residue.<br><br>The plastic bag covering the clean ready-to-use stand mixer utensils was observed heavily soiled with accumulated and encrusted food residue.<br><br>The protective nylon meshed bag covering the stand mixer was observed heavily soiled and sticky with accumulated and encrusted food residue.<br><br>The Vulcan oven(s) exterior surface (door fronts and ledges) were observed soiled with accumulated and encrusted food residue.<br><br>The Vulcan oven(s) backsplash panel was observed heavily soiled with accumulated and encrusted soil deposits. The backsplash panel surface was further observed blackened from accumulated and encrusted soil deposits. Executive Chef I indicated he would have staff thoroughly clean and sanitize the backsplash panel as soon as possible.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Vulcan deep fat fryer cabinet interior was observed heavily soiled with accumulated and encrusted grease/soil deposits. Executive Chef I indicated he would have staff thoroughly clean and sanitize the fryer cabinet interior as soon as possible.<br><br>The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.<br><br>Long Term Care Sub-Kitchen:<br><br>The ceiling mounted Slim [NAME] air conditioning unit filters and grill cover were observed heavily soiled with accumulated and encrusted dust and dirt deposits. The air conditioning unit was also observed located directly above the steam table. Executive Chef I indicated he would contact maintenance for necessary repairs as soon as possible.<br><br>The 2017 FDA Model Food Code section 4-602.13 states: NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.<br><br>On 07/18/24 at 9:00 A.M., Record review of the Policy/Procedure entitled: Cleaning Schedule dated (no date) revealed under Policy: The healthcare community stores, prepares, distributes, and serves food in a sanitary manner to prevent foodborne illness. Record review of the Policy/Procedure entitled: Cleaning Schedule dated (no date) further revealed under Procedure: A daily cleaning schedule will be posted in the kitchen with specific cleaning assignments to include both routine cleaning/sanitizing tasks along with deep cleaning tasks.<br><br>On 07/18/24 at 09:15 A.M., Record review of the Policy/Procedure entitled: Cleaning Procedure for Equipment and Utensils dated (no date) revealed under Policy: Equipment and utensils used in food preparation will be cleaned and sanitized according to standard procedure. Person in charge may post a schedule for cleaning assignments. Record review of the Policy/Procedure entitled: Cleaning Procedure for Equipment and Utensils dated (no date) further revealed under Procedure: Meat Slicer: (1) Unplug machine., (2) Set blade control to zero., (3) Disassembly machine. Loosen ring on slicer. Remove blade, pan, etc., (4) Wash the removable parts and the stationary parts, giving special attention to sharp edge, threads, and grooves., (5) Rinse., (6) Sanitize., (7) Air-dry on clean surface. May use clean paper towels or clean dry cloth to prevent rust., and (8) Reassemble machine and cover when not in use. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>22347<br><br>Based on observation, interview and record review, the facility 1) Failed to ensure that the residents' refrigerator was cleaned, and all food items were labeled and dated, and 2) Failed to analyze monthly infection control data, resulting in the high likelihood for resident infections, communicable disease outbreaks, increased antibiotic usage with continued infections and hospitalization s.<br><br>Findings Include:<br><br>Review of the facility Infection Prevention and Control Program dated 6/1/2020, stated The facility has a system in place (e.g., notification of IP by clinical laboratory) for early detection and management of potentially infectious symptomatic residents, including implementation of precautions as appropriate. Any unusual case or cluster of cases that may indicate a public health hazard.<br><br>On 7/15/24, at 10:38 am, in Family Dining room in the resident refrigerator, the following was observed:<br><br>-Food pieces and dried substances on the shelves and inside door.<br><br>-Two brown plastic bags with yogurt, and salad dressing, without dates.<br><br>-A container of spaghetti with meat balls, without any date on it.<br><br>-2 small quarter egg sandwich with no name or dates on them.<br><br>-1 open and partly used hard salami with no date.<br><br>-Five cheese ziti, no name or date.<br><br>-A plastic container of 2 pears, grapes, and 2 peaches that were starting to rot with no name or date.<br><br>-A container of shrimp, with no date.<br><br>-A plate of fish and chicken with rice, no date.<br><br>-A container of salad with meat, date 7/2/24 UB (use by this date) 7/8/24.<br><br>-A plastic baggie of bologna with no date.<br><br>-A container of opened and partly used miracle whip with no date.<br><br>-In the freezer, a cup of ice cream without name or date on it.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/15/24 at 10:55 a.m., during an interview, Infection Control Nurse, RN C stated All items have to labeled, guest name, dated, and room number on them, then discarded after 3 days. Dietary's job is to clean this refrigerator in the guest dining room; I have never gone and looked in this refrigerator. Nurse C was not aware of a facility policy for cleaning the resident refrigerator.<br><br>On 7/15/24 at 11:02 a.m., during an interview with Director of Nursing/DON, she stated It (residents' refrigerator) definitely needs to be cleaned.<br><br>On 7/15/24 at 1:07 p.m., the facility Infection Control Program was reviewed with Nurse C. Review of all data collection, line listings and policies revealed no documentation of any analyzing of monthly data.<br><br>Review of the facility April, May and June 2024's monthly summary's, revealed numbers of total infections and numbers of residents on antibiotics only. No documentation of any analyzing of this data was available.<br><br>On 7/15/24 at 1:30 p.m., Nurse C stated All I got was two days of training; she had not been trained on how to analysis data. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050<br><br>This citation has two Deficient Practice Statements (DPS).<br><br>Deficient Practice Statement 1<br><br>Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant affecting 50 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage.<br><br>Findings include:<br><br>On 07/15/24 at 12:05 P.M., The [NAME] microwave oven interior was observed (etched, scored, particulate), within the Family Dining Room. The hand sink basin overflow rim was also observed (etched, scored, chipped) in three areas. The cast iron sub-surface was further observed readily visible, within each chipped area.<br><br>On 07/15/24 at 02:40 P.M., A common area environmental tour was conducted with Director of Environmental Services A. The following items were noted:<br><br>Occupational Therapy/Physical Therapy: The Whirlpool refrigerator and freezer interior compartments were observed heavily soiled with accumulated and encrusted food residue. The microwave oven was also observed (etched, scored, particulate), within the interior door surface frame. Director of Environmental Services A indicated he would have staff remove and replace the faulty microwave oven as soon as possible.<br><br>Staff Break Room: Two 48-inch-wide particle board tables were observed (etched, scored, raised, particulate). Five of five fabric cushioned metal chairs were also observed (etched, scored, particulate). The inner Styrofoam padding was further observed protruding from the seat cushion surface on 4 of 5 chairs. The microwave oven and staff refrigerator were also observed soiled with accumulated and encrusted food residue. Director of Environmental Services A indicated he would have staff discard the worn items as soon as possible.<br><br>On 07/18/24 at 10:30 A.M., Record review of the Policy/Procedure entitled: Housekeeping Staff dated (no date) revealed under Purpose: A housekeeper is responsible for the cleaning and neat appearance of the facility.<br><br>On 07/18/24 at 10:45 A.M., Record review of the Policy/Procedure entitled: Maintenance Laborer dated (no date) revealed under Purpose: Assist the Maintenance Supervisor in carrying-out the responsibilities of the facility. Record review of the Policy/Procedure entitled: Maintenance Laborer dated (no date) further revealed under Definition: The Maintenance Laborer is responsible for taking direction from the Maintenance Supervisor in general maintenance and repair of the building and grounds.<br><br>22347<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Deficient Practice Statement 2<br><br>This Citation pertains to Intake Number MI00144812 and MI00145572.<br><br>Observation done on 7/15/24 at 11:00 a.m., of room [ROOM NUMBER] revealed heavily scuff marks (by wheelchair) on all the walls and the doorway. In the bathroom by the door on the floor, there were an extraordinarily large amount of paint chips stuck to the floor; they had been mopped over several times by housekeeping staff.<br><br>During an interview done on 7/15/24 at 12:13 p.m., Director of Housekeeping/Maintenance Supervisor A stated We are finally staffed fully. It (the paint chips on the floor in the bathroom) won't mop up, you have to take a scraper and physically do it; most of it is because of the employees.<br><br>Observation made on 7/15/24 at 11:30 a.m., revealed the dark blue wall at the end of Hall 100 and near the main dining room, had several large areas of white patched drywall mud that had not been sanded and painted.<br><br>During an interview done on 7/15/24 at 12:13 p.m., Director of Housekeeping/Maintenance Supervisor A stated we are in the process of patching the wall, last week we patched it.<br><br>During an interview done on 7/15/24 at 12:26 p.m., the Director of Nursing/DON stated The paint chips on the floor, we picked it up on our rounds, and repairs are going to be made but I just don't how long it is going to take.<br><br>Observation made on 7/16/24 at 12:16 p.m., in room [ROOM NUMBER] revealed, soiled clothing in a opened, clear plastic bag in the closet on the floor; the room had a heavy urine odor from this bag. The carpet by the door had large areas of darker colored stains. Black scuff marks (from wheelchair) were on the walls and door.<br><br>During an interview done on 7/16/24 at 12:30 p.m., Family Member F (room [ROOM NUMBER]) stated The carpet is dirty and there are black marks on (the) wall and door. (Family member) was always clean; in the closet is a bag of dirty clothes. I have been doing her laundry because no one will do it. I put her clothes in the washer here.<br><br>Review of the handwritten (facility name) Rounds and Repair List (un-dated) done and given to this surveyor on 7/17/24 at approximately noon by Housekeeping and Maintenance Supervisor A revealed, a total of 51 rooms with the repairs listed that needed to be done.<br><br>Review of the facility Housekeeping Staff responsibilities (un-dated), stated that housekeepers were to conduct through cleanings as scheduled, sweep and mop floors, and clean carpets. |