STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to accommodate resident choice regarding morning schedule for 1 (Resident #8) of 14 sampled residents reviewed for resident choices, resulting in feelings of frustration and the potential for Resident #8 being unable to meet their highest practicable level of well-being. Findings include: Resident # 8 Review of an Admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 8/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #8 was cognitively intact. Review of Resident #8's Care Plan revealed, Profile Care Guide: Approach: Prefers to be up by 8:00 AM all days to have breakfast in AL (Assisted Living). Approach Start Dare: 6/23/22 . Review of Resident #8 Concern Forms revealed, Date 10/15/24 . Concerned Person: (Resident #8). Nature of Concern: (Resident #8) not being out of bed in morning. (Resident #8) requests to have her morning care started early. Resolution: Satisfactory. Will educate staff on (Resident #8's) request for care to start early morning. Profile care updated. Resolved by Director of Nursing (DON) B on 10/15/24 Review of Resident #8 Concern Forms revealed, Date: 9/25/24: Concerned Person: (Resident #8). Nature of Concern: Getting up for breakfast. (Resident #8) reports that she would like to be up and in her chair so that she can go over to AL to eat breakfast (as she does for lunch and dinner), but that she usually isn't up and in her chair until much later in the morning. (Resident #8) is requesting to be up in her chair by 7 am or at least have nursing staff in getting her up at 7 am . Resolution: Satisfactorily- Daily huddles are being done. Apologized to (Resident #8). Will continue with educating staff on providing good service. Resolved by DON B on 10/2/24 . (continued on next page)

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
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/15/24 at 9:46 AM, Resident #8 was lying in her bed. It was noted that Resident #8 was in her pajamas and had not had morning care yet. Resident #8 reported that she liked to get up around 8:00 AM to eat breakfast, but she often had to wait until much later in the morning for staff to come assist her. Resident #8 reported that she had talked to the facility management about her desire to be up earlier in the morning several times. Resident #8 reported that the facility would accommodate her request for a few weeks but that the facility would always return to getting her up later than she desired. Resident #8 voiced frustration with being stuck in bed and waiting for staff assistance late in the morning, and missing the opportunity to eat breakfast in the dining room. During an interview on 10/17/24 at 11:21 AM, Licensed Practical Nurse (LPN) N reported that getting Resident #8 up at the time she desired was challenging for staff because the hall that Resident #8 was on had several residents that required assistance and staff struggled to get to residents on time. LPN N was not sure what interventions the facility had tried to accommodate Resident #8's request of getting up by 8:00 AM. LPN N confirmed that Resident #8 had voiced concern over not getting up at the time she would like multiple times, and that this was an ongoing issue for Resident #8 and the facility. During an interview on 10/17/24 at 12:36 PM, DON B reported that Resident #8's care profile directed staff to get Resident #8 up by 8:00 AM. DON B confirmed that she had completed a concern form for Resident #8 on 9/25/24 related to Resident #8's concern that her morning care was being given much later than she desired. DON B reported that she had educated staff regarding Resident #8's desire to be up for the day by 8:00 AM. DON B could not recall how she educated staff. DON B was not able to report why Resident #8 had not been provided morning care until after 9:45 AM on 10/15/24. DON B reported that she did not feel that the staffing on Resident #8's hall was an issue, and that staff were able to accommodate Resident #8's request if they prioritized resident care appropriately. DON B reported that the facility had not looked into any other interventions to assist with ensuring Resident #8 was receiving morning care at her desired time, as she (DON B) did not feel there was anything else that needed to be done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to provide a written notice of transfer for one resident (Resident #15) of two residents reviewed for hospitalization s, resulting in the potential of residents and/or resident representatives being uninformed of the reason for transfer and their rights. Findings include: Resident #15 (R15) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R15's admitted was 3/26/2019. Brief Interview for Mental Status (BIMS) score was a 99 which indicated her BIMS couldn't be completed due to her cognition level. R15 was discharged to the emergency roiagnom on [DATE] due to chest pain and shortness of breath and returned to the facility on [DATE]. Review of R15's chart revealed she had a guardian and there was no evidence that R15/her guardian received a written notice of transfer when she went to the hospital and which included the following information: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged ; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 1:12 PM, Nursing Home Administrator (NHA) A stated that R15's transfer notice wasn't completed and was forgotten by the nurse when she was sent out to the hospital on 6/28/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to notify the resident/resident representative of the facility bed hold policy and provide a written copy upon hospital transfer for one resident (Resident #15) of two residents reviewed for hospitalization s, resulting in the potential of residents and/or resident representatives being uninformed of the bed hold policy. Findings include: Resident #15 (R15) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R15's admitted was 3/26/2019. Brief Interview for Mental Status (BIMS) score was a 99 which indicated her BIMS couldn't be completed due to cognition level. R15 was discharged to the emergency roiagnom on [DATE] due to chest pain and shortness of breath and returned to the facility on [DATE]. Review of the R15's chart revealed she had a guardian in place and there was no documentation that R15/her guardian received a written bed hold notice upon transfer to the hospital. During an interview on 10/17/2024 at 1:12 PM, Nursing Home Administrator (NHA) A stated that she couldn't find that a bed hold notice was given to R15/her guardian in her chart upon her transfer to the hospital on 6/28/2024. NHA A stated that it should have been given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation and interview the facility failed to discard expired tube feeding supplements. These conditions resulted in an increased risk for contaminated foods and an increased risk of food borne illness for residents who might be prescribed these specific supplements. Findings include: During a tour of the 500 hall central supply storage room, at 11:15 AM on [DATE], it was observed that 35 bolus containers of Jevity supplement were found to all have a manufactures expiration date of 1MAY2024. At this time, Scheduling Coordinator G was going through the room discarding some expired product. An interview with Scheduling Coordinator G found that sometimes the facility doesn't have a resident who needs these items, and we don't end up going through them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 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. 38905 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food in the kitchen. Findings include: During a tour of the facility, at 8:40 AM on 10/16/24, an interview with Food Service Director (FSD) F, found that hand washing should take place for 20 seconds. During an observation of lunch service, starting at 12:14 PM on 10/16/24, it was observed that [NAME] EE, was on the serving line going through the process of making and plating alternates and puree menu items. At this time, it was observed that [NAME] EE would occasionally use his apron for wiping his gloves off as they got soiled. It was also observed that [NAME] EE used a towel on a preparation table as well as a towel he placed on his apron, to occasionally wipe his gloved hands. Over the course of service, it was observed that [NAME] EE changed his gloves twice without washing his hands in between gloves changes. After the third time [NAME] EE changed his gloves, he was observed at the hand sink washing his hands for roughly five seconds before drying them with paper towel, donning gloves, and getting back on the line to plate more meals. According to the 2017 FDA Food Code section 2-301.12 Cleaning Procedure. (A) Except as specified in (D) of this section, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a HANDWASHING SINK that is equipped as specified under S 5-202.12 and Subpart 6-301.(B) FOOD EMPLOYEES shall use the following cleaning procedure in the order stated to clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands and arms: (1) Rinse under clean, running warm water; (2) Apply an amount of cleaning compound recommended by the cleaning compound manufacturer; (3) Rub together vigorously for at least 10 to 15 seconds while: (a) Paying particular attention to removing soil from underneath the fingernails during the cleaning procedure, and (b) Creating friction on the surfaces of the hands and arms or surrogate prosthetic devices for hands and arms, finger tips, and areas between the fingers; (4) Thoroughly rinse under clean, running warm water; and (5) Immediately follow the cleaning procedure with thorough drying using a method as specified under S 6-301. 12 . According to the 2017 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: .(F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; . (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the kitchen, at 9:05 AM on 10/16/24, it was observed that underneath the preparation sink area was found with an increased amount of debris and with an accumulation of yellow staining. During a tour of the kitchen, at 9:18 AM on 10/16/24, it was observed that under and behind the ice machine was found with increased dirt and debris. Observation of some kitchen utensils, including a fork, dessert cup, and plastic ramekin were found under and behind the machine. During a tour of the pop closet, at 9:30 AM on 10/16/24, found that the floor in this area had a heavy accumulation of syrup and sticky debris on the floor and under the syrup storage rack. During a tour of the drink station, at 9:32 AM on 10/16/24, it was found that non-food contact portions of the underside of the juice dispensers were found with orange and brown sticky debris accumulation. When asked how often this area gets cleaned, FSD F stated the spouts are cleaned every day. Further observation found brown and black accumulation on the backside of the ice machine spout. Unsure of how the ice spout gets taken off, FSD F stated he would have to reach out to the vendor and see how to service that part. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (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. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . Dish Machine - During a tour of the dish machine area, at 9:25 AM on 10/16/24, an interview with FSD F found that staff record the temperatures of the machine every morning to ensure it is working properly. No issues were noted on the October log, with the machine being checked once a day around 6:30 AM. Observation of the dish machine's data plate found that it stated the wash cycle temperature needed to be 160F or higher and the rinse temperature needed to be a minimum of 180F. At this time, the surveyor tested the machine with a dish plate thermometer and ran the unit three times. The unit was found to only achieve a wash temperature between 148F-155F and a rinse temperature of 175F-180F between the three full cycles observed. The dish plate thermometer, with a minimum contact of 160F, reached between 145F-152F during the three cycles. FSD F stated that they were getting someone out to service the machine. During a tour of the kitchen at 11:55 AM on 10/16/24, an interview with Dish Machine Vendor FF found that a thermostat in the unit was burned out and needed to be replaced. According to the 2017 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90C (194F), or less than: .(2) For all other machines, 82C (180F). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions. Observation of the 500 Hall central supply room, with Regional Director of Plant Operations DD and Director of Plant Operations E, at 2:28 PM on 10/16/24, found two bottles of Uti-Stat urinary tract supplement with a manufacture's expiration date of 17MARCH2024. One of the bottles was observed with an open date of today, 10/16/24. Regional Director of Plant Operations DD discarded both bottles. According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (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 .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 - Some	Provide and implement an infection prevention and control program. 47659 Based on interview and record review, the facility failed to implement a system of infection control surveillance to identify possible infections or communicable diseases resulting in the potential for the development and transmission of communicable diseases and infections. Findings include: In an interview on 10/16/24 at 2:00 PM, Infection Preventionist (IP) CC reported that she was recently hired as the facility's full time infection preventionist. IP CC and Clinical Regional Support (CRS) AA reported that multiple staff members had been covering the Infection Preventionist Role over the last year. IP CC was asked to show and discuss what kind of infection prevention education had been provided to staff over the last year, and IP CC and CRS AA were not able to provide any evidence that the staff that had been covering the IP role over the last year had provided the staff with any education on infection prevention. CRS AA reported that all facility staff were provided with education at orientation and annually via the facility's online learning platform, but they did not know if any other education had been provided to staff. IP CC was asked to show and discuss the facility's infection control surveillance data for the last year. IP CC reported that she had not been keeping track of all residents with infections or possible infection symptoms, and only had a list of residents that had been prescribed an antibiotics to review. CRS AA reported that the facility had a way to run an infection event tracking report in the facility's EHR (Electronic Health Record). IP CC reported that any time the facility had a resident admitted or diagnosed with an infection, the event would be opened and tracking would occur through the EHR. IP CC confirmed that the infection even tracking was not created for residents with possible infection symptoms. IP CC was asked to show and discuss infection control audits that had been completed in the last year by the facility, and IP CC reported that she had not been documenting the audits that she had done. IP CC and CRS AA were not able to provide evidence of any infection control audits that had been completed in the last year. IP CC confirmed that she was still being trained by CRS AA, Director of Nursing (DON) B and an Infection Preventionist that had transferred to another building. IP AA reported that she had been trained on infection control surveillance and the process of monitoring infections and possible infections. During this interview, this surveyor requested documentation of infection surveillance, infection prevention and control education provided to staff in the last year, and infection prevention and control audits from the last year. CRS AA and IP CC reported that they would try to find the requested documents for this surveyor to review. During a follow up interview on 10/17/24 at 12:14 PM, IP CC showed this surveyor a binder the facility had used for 2024 which included line listings and mappings for infections. IP CC confirmed that the line listings and maps were not something IP CC had utilized. IP CC also provided a huddle note from 10/04/2024 that revealed Nurse topic: Infection prevention- medication and treatment cart : 1. Keep area clean and presentable. 2. Avoid personal belongings on stations such as food or drink. 3. When leaving station lock/close computer and medication drawers. 4. Label daily applesauce, pudding, water, cooler. 5. Check sharps container and change if full. 6. Night shift to stock straws, cups, spoons, med cups, ice, pudding, apple sauce . IP CC was not able to provide any other evidence of staff infection prevention education or infection control audits from the last year. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 - Some	During a follow up interview on 10/17/24 at 12:36 PM, this surveyor requested verification of staff infection prevention education and infection control audits from the last year to CRS AA. This surveyor queried CRS AA about the staff that had been responsible for the infection control program over the last year, and CRS AA reported that there had been several staff covering the program at different times, and she was not sure what each staff members method was for documenting infection control surveillance. On 8/17/24 at 3:16 PM, the facility provided additional documentation that the facility had educated staff on Enhanced Barrier Precautions on 4/2/24. The facility also provided a sign in sheet titled Education Huddle on Infection Control but there was no additional information included on what type of infection control education was provided. The facility did not provide any documentation of infection control audits prior to survey exit. Review of the facility's Infection Prevention and Control Program policy dated 12/31/23 revealed, . PURPOSE: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . 2. The campus shall designate a member of the clinical team to monitor the campus IPCP program to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting for the IPCP .b.Surveillance activities to identify, investigate, control, and prevent the spread of infection. Infections shall be tracked per hall/unit, type of infection, and monitor lab reports to identify organism(s). c. Reviews and critiques infection surveillance reports and statistics, recommending appropriate action for Healthcare Associated Infections (HAI) and Community Acquired Infections (CAI).Not limited to, documentation in resident ' s Electronic Health Record, reports available from lab vendor, and other reports available implementations and effectiveness of recommended actions. e. Monitors compliance with infection control practices and procedures. f. Ensures timely infection control education and training at orientation, regularly scheduled in-services and as needed in response to identified problems health status of residents (i.e., identifies those at risk for infection; reviews immunization status, etc.) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure residents were screened for eligibility to receive pneumococcal and influenza vaccinations and receive vaccination if eligible for 2 (Resident #8 and #10) of 5 residents reviewed for vaccinations, resulting in the potential of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia and/or influenza. Findings include: Resident #8 Review of an Admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness. Review of Resident #8's Electronic Health Record (EHR) did not reveal Resident #8's pnuemococcal immunization administration record. During an interview on 10/16/24 at 2:00 PM, Infection Preventionist (IP) CC reported that Resident #8 had last received the PVC 13 (pneumococcal vaccine) on 11/8/22. IP CC reported that Resident #8 was due for the PVC 20 (pneumococcal vaccine). IP CC was not able to confirm if Resident #8 had been offered to receive the PVC 20 vaccine. Resident #10 Review of an Admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care. Review of Resident #10's Electronic Health Record (EHR) did not reveal Resident #10's influenza immunization administration record. During an interview on 10/16/24 at 2:00 PM, Infection Preventionist (IP) CC reported that Resident #10 had last received an influenza vaccine on 10/6/22. IP CC was not able to confirm if Resident #10 had been offered an influenza vaccine in 2023. IP CC reported that she had been working through getting all of the residents caught up on vaccines, as this was something that had been missed with multiple changes in staff that were monitoring the infection control program. A request for Resident #8 and Resident #10's immunization record was made to Nursing Home Administrator (NHA) A on 10/17/24 at 3:08 PM via email. On 10/17/24 at 3:10 PM, NHA A reported via email that the facility did not have immunization records for Resident #8 and #10. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Guidelines for Influenza, Pneumococcal, & COVID-19 Immunizations policy last revised 12/31/23 revealed, . PURPOSE: To establish an immunization program that facilitates providing education to residents and resident representative allowing them to make an informed decision regarding immunization and to follow through per their decision to receive or not to receive immunization unless medically contraindicated. PROCEDURES: 1. Upon admission each resident/resident representative will be provided with information regarding the risk and benefits of influenza, pneumococcal, and COVID-19 immunization. A copy will be retained in the medical record. 2. Upon admission, each resident/resident representative will sign an informed consent form indicating the acceptance/refusal of immunization. A copy will be retained in the medical record and results added to preventative health record in EHR .4. Each resident/responsible party will be provided annually with information regarding the risk and benefits of influenza vaccine and receive the immunization per their request, unless medically contraindicated .6. Each resident will be offered, unless medically contraindicated, or already vaccinated, a pneumococcal vaccine per attending physician ' s orders. a. The campus will make efforts to determine if the resident has already received a pneumococcal vaccine and date received. b.If a date and type of vaccine cannot be determined, the facility will offer to restart the series per the CDC recommendations .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure COVID-19 immunization were offered to 1 (Resident # 25) of 5 residents, reviewed for COVID-19 immunizations, resulting in the higher likelihood of infection and complications from COVID-19. Findings include: Resident #25 Review of an Admission Record revealed Resident #25 was originally admitted to the facility on [DATE] with pertinent diagnoses which included end stage renal disease. Review of Resident #25's Electronic Health Record (EHR) did not reveal Resident #25's Covid-19 immunization administration record. During an interview on 10/16/24 at 2:00 PM, Infection Preventionist (IP) CC reported that Resident #25 had last received a Covid-19 immunization on 10/6/22. IP CC was not able to report if Resident #25 had been offered a Covid-19 immunization in 2023. IP CC reported that she was currently trying to catch up all resident vaccines in the facility, as this was something that had been missed with multiple changes in staff covering the infection preventionist role. A request for Resident #8 and Resident #25's immunization record was made to Nursing Home Administrator (NHA) A on 10/17/24 at 3:08 PM via email. On 10/17/24 at 3:10 PM, NHA A reported via email that the facility did not have immunization records for Resident #25. Review of the facility's Guidelines for Influenza, Pneumococcal, & COVID-19 Immunizations policy last revised 12/31/23 revealed, PURPOSE: To establish an immunization program that facilitates providing education to residents and resident representative allowing them to make an informed decision regarding immunization and to follow through per their decision to receive or not to receive immunization unless medically contraindicated. PROCEDURES 1. Upon admission each resident/resident representative will be provided with information regarding the risk and benefits of influenza, pneumococcal, and COVID-19 immunization. A copy will be retained in the medical record .3. The campus Medical Director and/or Provider should review with the resident and/or resident representative recommendations for Influenza, pneumococcal, and COVID-19 vaccinations .13. COVID-19 Boosters will be offered and given based on current CDC recommendations .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on observation, interview, and record review, the facility failed to make sure the call light for two residents (Resident #35, Resident #5) of 14 residents reviewed had an operable call light, which could potentially result in delayed response and negative resident outcomes. Findings include: Resident #35 (R35) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R35 admitted to the facility on [DATE] with diagnoses of heart failure, depression, weakness and insomnia (difficulty falling and staying asleep). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated she was cognitively intact (13 to 15 cognitively intact). During an interview on 10/15/2024 at 11:01 AM, R35 stated that her call light wasn't working. This surveyor turned on her call light and observed that it wasn't turning on to alert staff she needed help. R35 said that her call light works and then doesn't work at times. During an observation on 10/15/2024 at 11:23 AM, Certified Nursing Assistant (CNA) C pressed R35's call light multiple times before it worked. CNA C' notified a nurse that the call light wasn't working and it was replaced. During an interview on 10/16/2024 at 8:39 AM, Director of Plant Operations (DPO) E stated that he gets work orders for call lights every now and then and has looked at R35's call light a few times and hasn't found a problem. DPO E said he received work orders for her in the past and would go in there and didn't find it wasn't working. DPO E stated that he had to replace the call light cord once but hasn't found an issue since then. When asked if he conducts audits on call lights, DPO E stated that he has not done any since he started working at the facility. During another interview on 10/16/2024 at 8:59 AM, DPO E clarified that he doesn't have any work orders regarding the call light for R35. DPO E said most concerns from staff are verbal and it's hard to get staff to fill out work orders. During another interview on 10/16/2024 at 9:08 AM, R35 stated that when she had an issue with call lights in the past, it took days for someone to come and check it out and she wasn't given a call bell. She stated that the communication to pass it on from the nurse to maintenance to get it fixed is not good. When asked what she does when she needs help when the call light isn't working, R35 stated that she grabs her walker and goes down the hall to find help but she said she was worried about other residents who can't do that. During an interview on 10/16/2024 at 9:39 AM, CNA O stated that R35 has told her about call light issues in the past. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 11:05 AM, Nursing Home Administrator (NHA) A stated that there weren't any grievances regarding R35's call light until 10/15/2024 when this surveyor identified it wasn't working. Review of the Guidelines for Inoperable Light System Policy with an effective date of 5/11/2016 and a review date of 12/31/2023 revealed PROCEDURES: .3. A bell or other sound making device shall be provided for residents that are able to use the call system. 4. A staff member shall be assigned to round in the campus to identify residents requiring assistance. 35981 Resident #5 Review of an Admission Record revealed Resident # 5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: paralysis of the right side after a stroke. Review of a Minimum Data Set (MDS) assessment for Resident #5 with a reference date of 7/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #5 was cognitively intact. In an interview on 10/16/24 at 03:01 PM., Resident #5 reported she had fallen a weeks ago in her bedroom because the call light was not working. Resident #5 reported she had to yell out help help while she was on the floor after the fall. Resident #5 reported she had initially pressed the call light it to get up but no one came until she called for help. In an interview on 10/16/24 03:07 PM CNA GG reported a few weeks ago Resident #5 had fallen trying to get to get into her bed. CNA GG reported she recalled the call light was not working at the time of Resident #5's fall. CNA GG reported the call light had to be replaced after Resident #5 was assisted and assessed for injuries. CNA GG reported Resident #5 had no injuries from the fall. Review of Resident #5's Electronic Medical Record (EMR) nursing progress note revealed Nursing progress note-10/05/2024 07:37 PM., (Resident #5) was observed in supine position on floor, next to right side of bed. Her (Resident #5) head was at the foot of bed, with her feet facing head of bed. (Resident #5) did not have any socks or shoes on at the time of fall, as she removed them prior to self transferring. (Resident #5) stated she pushed her call light for assistance. Call light was not on at the time of fall, and it was noted to not be working properly when this nurse tested it. Call light was immediately exchanged for one that is functioning properly. Head to toe assessment completed on (Resident #5) with no apparent injuries observed (Resident #5) denies pain/discomfort r/t (related to) fall. With multiple staff assistance (Resident #5) was removed from floor and assisted to bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235639	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Byron Center	2280 Byron View Dr SW Byron Center, MI 49315

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Electronic Medical Record (EMR) nursing progress note revealed Nursing progress note-10/07/2024 IDT (Interdisciplinary Team) met on 10/7/24 to review fall that occurred on 10/5/24. (Resident #5) was observed on floor in her room next to her bed. IDT was informed by nurse that (Resident #5) was trying to self transfer from wheelchair into her bed and ended up falling. Nurse observed resident to have bare feet with no socks or shoes on at time of fall. (Resident #5) did state that she activated her call light but no one came to help her. Nurse assessed call light and observed that it was not functioning properly. (Resident #5) denied having any pain. A head to toe assessment done. No injuries observed. Neuros and vitals taken. Provider and family were notified. (Resident #5) has a BIMS of 14/15. She is diagnosed with hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysarthria following cerebral infarction vascular dementia Root Cause Analysis: (Resident #5) self transferred. She is a two person assist using sit to stand for transfers and is aware of this. Resident did not have on proper footwear during self transfer. Immediate intervention: Call light was immediately exchanged for one that is functioning properly. Intervention: Ensure resident has her grippy socks on or shoes with staff member assisting her with transfers. Intervention in place and care plan updated . 38905 An interview with Director of Plant Operations (DPO) E, at 2:45 PM on 10/16/24, found that call lights are on a wireless system and that DPO E gets notifications when there is an issue with some parts of the system not working, such as the battery dying on the wall mounted unit. DPO E went on to state that when the cord or light bulb is not working, that he only finds out through staff submitting work orders. When asked if he has ever come to fix a call light and found that the cord has been found partially pulled out of the socket and needed to be reinserted a fraction to work, DPO E stated its happened sometimes. When asked about other issues with call lights, DPO E stated that on occasion he has found that some residents are confused about how to use the call system and don't press the button and instead press the side of the handheld unit of the call system that doesn't engage the light. They also use back up bells when there are issues with call lights they are working on.