STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235651	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Noa Home for Senior Citizens	2900 Third Avenue South Escanaba, MI 49829

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 Based on observation, interview, and record review the facility failed to ensure resident shared equipment was properly cleaned and sanitized. Findings include: On 3/4/25 at 4:10 PM., a sit to stand lift was observed parked outside of room [ROOM NUMBER]. The base of the lift (where residents plant their feet) was noted to be heavily soiled with dirt, debris and food crumbs. The padded knee area (where residents shins are pressed against for stability) beige in color was noted to be soiled with dried, crusted stuck on substances. The padded arms (beige in color) were also noted to be soiled with grime, the mechanical body of the lift had a heavy accumulation of dust and overall the sit to stand was noticeably soiled. On 3/5/25 at 9:19 AM., a Hoyer lift was observed near room [ROOM NUMBER]. There were blue pads located on the lift and base which were visibly soiled with dried crusted substances, dust and debris. A medication cart next to room [ROOM NUMBER] was observed with a pill crusher on it, which was heavily soiled with white crushed pill dust, dirt and grime in the crevasses. There was a brown dried substance on the sides of the pill crusher. On 3/05/25 at 9:24 AM, a sit to stand lift was observed near room [ROOM NUMBER]. The base of the lift was soiled with dust, debris and food crumbs. The padded handles which were beige in color were noticeably soiled with dirt and grime. In an interview on 3/5/25 at 9:30 AM., Licensed Practical Nurse (LPN) D reported Certified Nurse Aides (CNA's) and any staff using lifts and resident shared equipment (such as lifts, scales, vital machines) were responsible for sanitizing the shared equipment after each use, and when noticeably soiled. LPN D reported the sanitizing wipes were located in the medication storage room, or soiled linen rooms. LPN D reported the CNA's have to ask a nurse to get wipes from the medication storage rooms because they are locked. LPN D reported the soiled linen rooms were locked but the CNA's and most staff have the key codes to get into those rooms. LPN D reported she was rarely asked to get sanitizing wipes for anyone from the medication storage rooms. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 9:36 AM., a sit to stand lift was observed parked outside of room [ROOM NUMBER]. The base of the lift was noted to be heavily soiled with dirt, debris and food crumbs. The padded knee area beige in color was noted to be soiled with dried, crusted stuck on substances. The padded arms were also noted to be soiled with grime, the mechanical body of the lift had a heavy accumulation of dust and overall the sit to stand was noticeably soiled. On 3/5/25 at 10:34 AM., a sit to stand lift was observed near room [ROOM NUMBER]. The base of the lift was soiled with dust, debris and food crumbs. The padded handles which were beige in color were noticeably soiled with dirt and grime. On 3/5/25 at 2:28 PM., a sit to stand lift was observed parked outside of room [ROOM NUMBER]. The base of the lift was soiled with dirt, debris and food crumbs. The padded knee area was noted to be soiled with dried, crusted stuck on substances. The padded arms were also noted to be soiled with grime, and the overall sit to stand was noticeably soiled. On 3/5/25 at 2:34 PM., a sit to stand lift was observed parked outside of room [ROOM NUMBER]. The base of the lift was soiled with dirt, debris and food crumbs. The padded knee area was noted to be soiled with dried, crusted stuck on substances. The padded arms were also noted to be soiled with grime, and the overall sit to stand was noticeably soiled. On 3/5/25 at 2:31 PM., a sit to stand lift was observed in room [ROOM NUMBER] with the beige pads and base soiled. An unidentified staff member brought the lift out of room [ROOM NUMBER] and parked it outside the door. The unidentified staff member left the lift without cleaning it and/or using sanitizing wipes which were located in the bag on the lift. The base was observed soiled and the legs of the lift were visibly soiled with dust, and grime. The frame was observed soiled in various areas with dried stuck on substances and an overall soiled/dingy appearance with food crumbs on base. There were no sanitizing wiped observed in the resident's room and none were observed in bathroom or under bathroom vanity sink. On 3/5/25 at 3:15 PM., a Hoyer lift was observed near room [ROOM NUMBER]. The blue padded handle covers were noted to be soiled with dirt and grime. The legs/base of the lift were noted to have an accumulation of thick dust, and dried spillage on various areas of the base and legs of the Hoyer lift. On 3/6/25 at 9:25 AM., during an interview, Patient Care Aide (PCA) G reported staff are supposed to clean any resident shared equipment before and after use. PCA G reported the facility has purple wipes available for use and they are usually stored in the soiled linen rooms. PCA G reported it would be nice if they were closer to the equipment, or in bags attached to the equipment. PCA G reported she thought that would help staff who might forget about wiping the equipment after use if they are busy. On 3/6/25 at 10:11 AM., a sit to stand lift was observed near room [ROOM NUMBER]. The base of the lift was soiled with dust, debris and food crumbs. The padded handles which were beige in color were noticeably soiled with dirt and grime. On 3/6/25 at 10:20 AM., a sit to stand lift was observed near room [ROOM NUMBER]. The base of the lift was soiled with dust, debris and food crumbs. The padded handles which were beige in color were noticeably soiled with dirt and grime. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 10:25 AM., a sit to stand lift was observed near room [ROOM NUMBER]. The base of the lift was soiled with dust, debris and food crumbs. The padded handles which were beige in color were noticeably soiled with dirt and grime. Review of a facility Policy & Procedure-Cleaning and Disinfecting of Resident Share Equipment with a revision date of 6/2024 revealed: Policy- Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA (Occupational Safety Health Administration) Bloodborne Pathogens Standard Procedure:1. The following categories are used to distinguish the levels of sterilization/ disinfection necessary for items used in resident care: a. Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue (e.g., urinary catheters) or the vascular system (e.g., intravenous catheters) are considered critical items and must be sterile. b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g. , respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. (Note: Some items that may come in contact with non-intact skin for a brief period of time (e.g., hydrotherapy tanks, bed side rails) are usually considered non-critical surfaces and are disinfected with intermediate-level disinfectants.) c. Non-critical items are those that come in contact with intact skin but not mucous membranes. 1. Non-critical resident-care items include but limited to bedpans, blood pressure cuffs, walkers and computers. 2. Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location). a. Reusable items are cleaned and disinfected or sterilized between residents. 1. Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards. a. Single-use items are disposed of after a single use. 2. Critical and semi-critical items will be sterilized/disinfected in a central processing location and stored appropriately until use. Equipment to be processed will be labeled with at least the following information: a. That the equipment is contaminated, b. The address to which the equipment is to be shipped, c. The address from which the equipment was removed (including telephone number); d. The name of the person labeling the equipment; and e. The date and time the label was affixed to the equipment. 2. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. 3. Reusable resident care equipment will be decontaminated and or sterilized between residents according to manufacturers' instructions .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34568 Based on observation, interview, and record review, the facility failed to ensure appropriate assessments, physician orders, and medical justification, for restraints that were in place for one Resident (R49) of one resident reviewed for restraints. Findings include: Resident #49 (R49) On 3/6/25 at 10:25 a.m., R49 was observed in a merry walker (a four wheeled walker with a seat and frame/crossbar locking the resident in the walker) ambulating down the hallway. R49's merry walker strap was observed attached to the back frame of the merry walker. R49 was observed attempting to enter another resident's room at the time and was redirected by staff. Review of R49's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with primary diagnoses of vascular dementia with agitation. A quarterly Minimum Data Set (MDS) assessment completed on 1/29/25 documented R49 as having short-term and long-term memory impairment with severely impaired cognitive skills for daily decision making. The MDS coded the use of a chair that prevents rising restraint less than daily for R49. There was no physician's orders for a merry walker. The Director of Nursing (DON) was interviewed on 3/6/25 at 10:51 a.m. The DON was asked about restraint assessments, physician orders and resident representative consent for the use of R49's merry walker. The DON confirmed R49 was first trialed and given a merry walker in November 2024 and that there was no resident representative consent signed until January 2025. The DON also stated that there was a delay in R49's care plan for the use of the merry walker, and R49 had no completed assessments. Review of the facility's Restraints and Seclusions policy dated 12/12/24 read, in part, It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints and seclusion for discipline, coercion, retaliation or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints . The policy did not discuss how the facility will determine the need for a physical restraint, physician order, assessments, consents, or care plans.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to ensure a recapitulation of stay was completed for one Resident (#66) out of one resident reviewed for for discharge to the community. Findings Include: Resident #66 (R66) Review of R66's electronic medical record (EMR) revealed admission to the facility on [DATE] for surgical aftercare following an intestinal obstruction. R66 was discharged from the facility on 1/30/25 following a short-term rehabilitation stay. Review of R66's EMR revealed no discharge plan, recapitulation of stay, nor reconciliation of pre- and post-discharge medications. On 3/6/25 at 9:28 AM, an interview was conducted with Registered Nurse (RN) M regarding discharge expectations. RN M stated each discipline was supposed to include a discharge progress note in the EMR. RN M was unsure why R66 did not have the expected discharge summaries in their EMR. On 3/6/25 at 9:34 AM, an interview was conducted with Licensed Practical Nurse (LPN) H regarding the discharge process. LPN H stated facility staff were required to review medications with the resident and complete discharge progress notes by discipline in the EMR. On 3/6/25 at 9:42 AM, an interview was conducted with the Director of Nursing (DON) regarding R66's discharge process. The DON confirmed a discharge summary by discipline was expected and was unsure why R66 did not have such in their EMR. The DON stated an official recapitulation of stay was not part of the facility's discharge process. However, the regulation explicitly stated one was required for such a discharge. Review of the facility policy titled, Discharge/Transfer, reviewed 6/2024, read, in part: .nursing staff will provide education and information to prepare resident for discharge .resident will be provided with education regarding medications that are ordered by the physician on discharge .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on observation, interview, and record review, the facility failed to ensure sanitary storage and proper cleaning of respiratory equipment for one Resident (#59) of one resident reviewed for respiratory services. Findings include: Resident #59 (R59) Review of R59's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including obstructive sleep apnea and asthma. Review of R59's most recent Minimum Data Set (MDS) assessment, dated 1/8/25, revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. On 3/4/25 at 3:12 PM, a continuous positive airway pressure (CPAP) mask and tubing were observed placed on R59's dresser with no protective covering. Supplemental oxygen tubing, including the nasal cannula, was also observed attached to a concentrator near the dresser, in direct contact with the floor. On 3/5/25 at 11:53 AM, R59's CPAP mask and tubing were again observed on the dresser with no protective covering. The supplemental oxygen tubing and cannula continued to be in direct contact with the floor. When asked about cleaning expectations, R59 stated the respiratory equipment was supposed to be cleaned daily but staff did not routinely clean the respiratory equipment. On 3/6/25 on 9:57 AM, R59's CPAP mask and tubing was again observed on the dresser with no protective covering. The supplemental oxygen tubing and cannula continued to be in direct contact with the floor. Review of R59's EMR revealed the following order, initiated 5/3/24: .CPAP machine with oxygen concentrator 2.5 L/m [liters/minute] use as directed .Apply at bedtime, remove at AM [morning]. Clean machine per manufactures instructions. On 3/6/25 at 10:31 AM, an interview was conducted with Certified Nursing Assistant (CNA) O regarding respiratory equipment storage expectations. CNA O was unfamiliar with the facility's cleaning or storage policy. On 3/6/25 at 10:35 AM, an interview was conducted with Registered Nurse (RN) N regarding CPAP and oxygen equipment storage expectations. RN N indicated the CPAP hose was supposed to be cleaned with water after every use and then hung to dry. RN N was unaware of a policy regarding storage of respiratory equipment when not in use. When asked what the manufacturer instructions for the cleaning of R59's respiratory equipment per physician's orders meant, RN N was unaware. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 10:49 AM, an interview was conducted with the Director of Nursing (DON) regarding the facility's respiratory cleaning and storage policies. The DON stated the CPAP tubing should be cleaned after each use and more thoroughly one time per week, unless otherwise indicated in the physician's orders. After reviewing R59's orders, the DON stated, clean per manufacturer's instructions is unclear and floor staff would not have access to such information. The DON indicated both the CPAP mask and oxygen cannula in direct contact with the dresser and floor, respectively, was an infection control concern as it would increase the risk of respiratory illness. Review of the facility policy titled, CPAP Equipment Cleaning Instructions, reviewed 1/23/25, read, in part: It is the policy of [Facility Name] to promote a clean environment by reducing and/or eliminating the risk for infection through proper cleaning of the equipment being used . the CPAP equipment will be cleaned on a regular basis . Review of the facility policy titled, Cleaning Oxygen Concentrators and Changing Oxygen Accessories, reviewed 6/2019, read, in part: .all tubing will be placed in a plastic bag attached to oxygen system when not in use .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 Based on observation, interview and record review, the facility failed ensure personal protective equipment (PPE) was worn by staff as required when caring for 1 Resident (#21) of 3 residents, reviewed for Enhanced Barrier Precautions (EBP). This deficient practice resulted in the potential for infection, communicable disease and multi-drug resistant organism transmission. Findings include: Resident #21 (R21) Review of the Admission Record for R21 revealed an original admitted to the facility on [DATE] with diagnoses including: Amyotrophic Lateral Sclerosis (ALS-progressive and fatal neurological disorder). Review of a Minimum Data Set (MDS) assessment for R21, with a reference date of 1/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated R21 was cognitively intact. Review of a facility Enhanced Barrier document on 3/6/25 at 9:04 AM., was noted on the outside wall/doorway of R21's room stating . CHECK WITH NURSE BEFORE ENTERING-STOP . In addition to Standard Precautions- High-Contact Resident Care Activities: ENHANCED BARRIER PRECAUTIONS (boxed checked) .(Activities on the sign were listed as follows) . Dressing, Bathing, Providing Hygiene, Caring for Devices (central lines, urinary catheters, feeding tubes, tracheostomy) . Transferring, Changing Linens, Toileting, Wound Care on the sign there were boxes with computerized images (a sink with water, a gown, gloves, a medical mask, stethoscope etc .) The boxes checked for R21's room were: Hand Hygiene, Gown and Gloves, and Not restricted to room . On 3/6/25 at 9:10 AM., 2 CNA staff were observed inside R21's room. CNA F was observed placing a Hoyer lift sling underneath R21 while lying in bed. CNA E walked into R21's room with a Hoyer lift which had been parked outside R21's room, near room [ROOM NUMBER]. CNA E did not sanitize the lift prior to entering R21's room. CNA F and CNA E were not wearing gowns, and CNA E was not wearing gloves. CNA F and CNA E proceeded to sit R21 up in her bed, adjust the lift sling, and CNA E moved the Hoyer into position to clip on the sling straps and attach them to the Hoyer lift with the help of CNA F. CNA F and CNA E adjusted R21 into the Hoyer lift and completed the transfer with the Hoyer lift from R21's bed into her electric wheelchair. CNA F and CNA E unclipped the sling from the Hoyer lift, and CNA E moved the Hoyer lift out of R21's bedroom into the hall and parked it near room [ROOM NUMBER]. CNA E did not wipe down the lift, perform hand hygiene or use hand sanitizer prior to exiting R21's room. CNA E re-entered R21's room and again, did not perform hand hygiene. On 3/6/25 at 9:23 AM., during an interview, CNA E acknowledged when transferring R21 both her and (CNA F) should have had sanitized the Hoyer lift before and after using it. CNA E confirmed all staff are required to perform hand hygiene either by use of soap and water for 20 seconds with the sink or use an approved hand sanitizer. CNA E acknowledged she did not follow proper infection control procedures. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 at 9:33 AM., during an interview, LPN H reported R21 was on EBP because she has a feeding tube. LPN H reported all staff providing care to R21 should use proper hand hygiene, gloves, and a gown. LPN H reported staff must wear a gown even if transferring to and from any equipment, bed to chair, shower, and toileting. LPN H reported resident shared equipment such as vital machines, lifts, and commonly touched surfaces should be wipes down with the sanitizing wipes, and after each use, and/or when visibly soiled. Review of R21's Physicians Orders dated 1/1/24 revealed: Change syringe for g-tube daily. Place date and time changed on new syringe when replacing every night shift for infection control . On 3/6/25 at 9:30 AM., during an interview, CNA F reported she should have been wearing a gown when doing morning care for R21. CNA F reported she was unsure exactly why the EBP was in place for R21, but thought it was because she (R21) had a feeding tube. CNA F reported she didn't think of putting on the gown, and she had not paid attention to the signage on the outside of the wall. CNA F reported she felt very bad that she didn't pay attention to the EBP sign and knows how important it is to protect the residents from possible infections. CNA F reported the facility has had many training's for the EBP protocol, but it had just slipped her mind today. CNA F stated I don't think I will ever forget to put it on again . CNA F stated that unfortunately sometimes mistakes were good, so that they learn from them, and they really give staff opportunities to improve.