

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235727	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  The Oaks at Belmont		STREET ADDRESS, CITY, STATE, ZIP CODE  6081 W River Drive Belmont, MI 49306	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905</b></p> <p>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.</p> <p>Findings include:</p> <p>During a tour of the kitchen, starting at 9:10 AM on 10/22/24, an interview with Assistant Food Service Director (AFSD) U, found that the facility routinely cools and uses a log for cooled items. A review of the log found items that have cooled the past couple days, but nothing on the log that is currently cooling.</p> <p>During an observation of the two-door true cooler, at 9:32 AM on 10/22/24, it was observed that a plate of two to three dozen sausage links, left over from breakfast service, was found tightly covered in saran wrap and placed in the cold hold unit. At this time, condensation was found on the inside of the saran wrap, and an initial surface temperature with an infra-red thermometer, found the sausages were over 70F, and in the process of cooling. When asked about the cooling sausages, AFSD U stated that it's not something we usually keep and it will be discarded.</p> <p>During a revisit to the kitchen, at 3:25 PM on 10/22/24, an interview with Food Service Director (FSD) T, found that she wasn't aware of any items cooling at this time. Observation of the cooling log found no items logged for cooling at this time.</p> <p>During a revisit to the walk-in cooler, at 3:27 PM on 10/22/24, two full six-inch-deep half pans of cheese sauce were observed covered tightly in saran wrap with heavy condensation on the inside top. Upon finding the half pans of cheese sauce, AFSD U brought the pans out on the preparation table and stated they should be cooling with an ice wand. Both pans were placed on the table with ice wands inserted. A temperature of the sauce was found to be over 120F at this time.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the 2017 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3) Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD.</p> <p>During a tour of the kitchen, at 9:35 AM on 10/22/24, an interview with FSD T found that the plastic bag over the mixers mean they are clean. Observation of the small mixer found an accumulation of dried debris around the underside rim of the mixing arm. Accumulation was able to be wiped off with a clean paper towel.</p> <p>During a tour of the clean pots and pans storage rack, at 9:40 AM on 10/22/24, observation found a stack of quarter size long pans that had an accumulation of dust and food debris on the rims and perimeter of the pans. When asked about the condition of the stacked pans. FSD T stated that they used to use the pans for a salad bar, but don't have a reason for them anymore. Further observation of the rack found two full pans stacked with moisture accumulation between them and two half pans with debris accumulation on the inside of the pans. Some of the debris was stuck on saran wrap on the perimeter of the pans and some of the debris was dried food on the inside portion of the pans.</p> <p>Observation of the expediting cart that is used to house baking equipment, at 9:44 AM on 10/22/24, found excessive flour and crumb debris on the rack [NAME] and shelf space used to store sheet pans and tubs with equipment. When asked if the items on this rack gets used. FSD T stated yes.</p> <p>Observation of the clean utensil drawer, on the preparation line, at 9:48 AM on 10/22/24, found three mechanical scoops with excess stuck on food debris on the inside of the ladle and behind the inside blade of the scoops. FSD T took the utensils out of the drawer.</p> <p>Observation of the under-counter microwave, at 10:01 AM on 10/22/24, found an increased amount of dried debris on the inside top of the unit.</p> <p>Observation of the preparation counter near the Robo-Coup, at 10:08 AM on 10/22/24, found excess accumulation of dried crumb debris in and on items stored in bus tubs under this preparation space. One bus tub was filled with molds for puree items and one bus tub was filled with attachments for the Robo-Coup. Some puree molds were found with stuck on food debris, resembling food from previous uses.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a tour of the dish machine area, at 10:30 AM on 10/22/24, observation of the dish machines data plate found that it requires minimum of 160F for the wash cycle and a minimum of 180F for the final rinse. Observation of the dish machine over the next three cycles found the wash gauge ranged from 145F-150F with a rinse pressure showing an inconsistent reading anywhere from 30-60+ pounds per square inch (psi). Further observation of the machine found the glass cover to the rinse gauge missing and leaking water under the unit. Using a flashlight to look under the machine, it was observed that the dish machines pressure relief valve was leaking into a cup positioned behind the unit. It was also observed that the gauge showing the pressure and temperature of the incoming hot water was found to be rusted with standing water inside of the gauge. When asked if the pressure gauge is something staff record, FSD T stated no. Observation of the log found that all appropriate temperatures were found this morning when the unit was checked.</p> <p>According to the 2017 FDA Food Code section 4-501.113 Mechanical Warewashing Equipment, Sanitization Pressure. The flow pressure of the fresh hot water SANITIZING rinse in a WAREWASHING machine, as measured in the water line immediately downstream or upstream from the fresh hot water SANITIZING rinse control valve, shall be within the range specified on the machine manufacturer's data plate and may not be less than 35 kilopascals (5 pounds per square inch) or more than 200 kilopascals (30 pounds per square inch).</p> <p>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.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36221</p> <p>Based on observation, interview, and record review, the facility failed to maintain infection control measures during incontinence care related to hand hygiene and glove use in 2 of 5 residents (Resident #6 &amp; #28) reviewed for infection control, resulting in the potential for cross-contamination and the development and spread of infection.</p> <p>Findings include:</p> <p>Review of the policy/procedure Handwashing/Hand Hygiene, dated 12/31/23, revealed .Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of antiseptic hand rub, also known as alcohol-based hand rub (ABHR) .Health Care Workers (HCW) shall use hand hygiene at times such as .After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen .</p> <p>Resident #6</p> <p>In an observation on 10/22/24 at 1:14 PM, Certified Nursing Assistant (CNA) E and CNA L assisted Resident #6 with incontinence care in her room. Observed CNA E and CNA L don gloves prior to initiation of incontinence care. Noted Resident #6's brief was visibly soiled with BM (bowel movement) which had leaked out of the side of the brief onto the pad below. Observed CNA E use pre-moistened wipes to clean Resident #6's perineal area in the front. CNA E and CNA L then turned Resident #6 onto her side, and CNA L used the pre-moistened wipes to wipe Resident #6's buttocks. Observed CNA L and CNA E remove the soiled brief/pad from below Resident #6 and place a new clean brief. CNA L then applied cream to Resident #6's perineal area and removed the soiled gloves. CNA E fastened Resident #6's brief, bagged the trash, and then removed and discarded the soiled gloves. Observed CNA E and CNA L don new pairs of gloves and continue care for Resident #6, which included dressing and assistance with a transfer to the bathroom to wash up for the day. No hand hygiene observed between glove changes.</p> <p>In an interview on 10/24/24 at 10:47 AM, CNA V reported hand hygiene should be completed between glove changes.</p> <p>In an interview on 10/24/24 at 12:09 PM, Registered Nurse (RN) W reported hand hygiene should be completed between glove changes with either hand sanitizer or hand washing.</p> <p>41027</p> <p>Resident #28</p> <p>Review of an Admission Record revealed Resident #28 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: nausea, vomiting, diarrhea and sepsis (a potentially life-threatening condition that arises due to the body's response to infection).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 10/23/24 at 10:28 AM, CNA E was in Resident #28's room preparing to provide incontinence care. CNA E was wearing gloves while removing Resident #28's brief and washing her private area. There was brown liquid BM (bowel movement), that was expelled two times during care. CNA E cleaned Resident #28 up and did not discard her gloves after the incontinence care. CNA E applied a clean brief on Resident #28, obtained cream from the dresser, applied the cream to the resident's private area, and then handled the resident's blankets, adjusted her pillow, and lastly, placed the bed controls and call light within the resident's reach. CNA E reported that she forgot to remove her gloves after incontinence care.</p> <p>In an interview on 10/23/24 at 1:30 PM, Assistant Director of Nursing/Infection Preventionist (ADON) C and Director of Nursing (DON) B reported that although they had educated and performed audits for hand hygiene, they had not observed staff performing incontinence care, to ensure that glove use and infection control measures were being maintained throughout the task.</p>		