STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	**4/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREPOINTE NURSING CENTER	**26001 EAST JEFFERSON AVENUE SAINT CLAIR SHORES, MI 48081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Shorepointe Nursing Center was surveyed for a Recertification survey on 4/14/25 - 4/16/25. Intakes: MI00151146, MI00151146, MI00151407, MI00151423, MI00152075, and MI00152118. Census: 169	F0000		
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The	F0656	Element 1 It is the practice of the facility to provide person centered interventions and care plans for patients with Vascular Dementia, PTSD and ESRD. R78 and R 46 care plans have been reviewed and updated. Element 2 Residents that have been diagnosed with Vascular Dementia, PTSD and ESRD have the potential to be affected by this cited practice. Those residents' care plans have been reviewed and updated. Element 3 The Interdisciplinary Team reviewed the policy and procedure to Develop/Implement Comprehensive Care Plan and deemed it appropriate. The Social Services and dietician have been educated on the policy of Develop/implement interventions and care plans with focus on to provide person centered interventions and care plans. Element 4 S.W/Designee will audit new admissions with diagnoses of Vascular Dementia, PTSD to ensure care plans are in weekly x4 then monthly x3. Dietician/Designee will audit renal patients to ensure non-compliance diet care plans are in place and will do random audits on renal patients for compliance with diet weekly x 4	5/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2025

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.

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	resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide person centered care plans for two sampled residents (R78 and R46) of three whose care plans were reviewed. Findings include: R78 A review of R78's medical record revealed an initial admission into the facility on 9/16/20, and a readmission date of 5/11/23 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Diabetes, Vascular Dementia, and Post-Traumatic Stress Disorder (PTSD). Further review revealed the resident was cognitively intact and required 1-2 person assist for activities of daily living. A review of R78's care plan did not reveal a care plan for the resident's diagnoses of Post-Traumatic Stress Disorder or Vascular Dementia. On 4/16/25 at 12:01 PM, Social Worker "A" was		weeks then monthly x 3 months. Results of audits will be taken through QA for further review and recommendations. The Administrator will be responsible for sustaining compliance.	

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	asked about R78's missing care plan related to their PTSD and Vascular Dementia and explained she would investigate and get back with the surveyor. At 1:14 PM, Social Worker "A" followed-up with surveyor and acknowledged the resident did not have a care plan for their diagnoses. On 4/16/25 at 1:56 PM, the Nursing Home Administrator was asked for her expectations for the implementation of care plans and acknowledged there should be appropriate care plans in place, and psych services as needed. R46 On 4/14/2025 at 10:02 AM, R46 was away from their room receiving a dialysis treatment. An observation of R46's belongings revealed one heel protector on the bedside chair and one on another surface next to the chair. On 4/14/24 at 1:30 PM, an interview with R46 revealed they had just returned from dialysis. R46 did not have their heel protectors on and was in bed on their back. An inquiry revealed R46 was comfortable and did not like the heel protector. A review of the Electronic Medical Record (EMR) revealed R46 was admitted to the facility on 3/29/2024 with pertinent diagnoses of Encephalopathy (chronic degeneration), Diabetes with neuropathy (decrease in sensation), Kidney Disease requiring dialysis, and pressure ulcer of the right heel. Further review of R46's EMR revealed a Basic Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive impairment. The EMR revealed R46 was depended for all activities of daily living except eating.			

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	On 4/15/2025 at 10:37 AM, an interview with Nurse Unit Manager (NUM) "H" revealed there should be a "non-compliance care plan" since R46 is known to refuse many aspects of their care. On 4/15/2025 at 10:51 AM, an interview with R46's family revealed R46 often refuses care. On 4/15/2025 at 12:25 PM, an interview with Licensed Practical Nurse (LPN) "F" revealed R46 often refuses care, does not like the food and requests items not within their dietary restrictions. On 4/15/2025 at 2:00 PM, an interview with Dialysis Nurse (DN), "N" revealed R46 had high potassium and high phosphorous levels at times. When queried regarding the cause, DN "N" revealed elevated potassium and phosphorous levels are usually due to non-adherence to a Renal diet. On 4/15/2025 at 2:30 PM, an interview with Dietician "M" revealed R46 is currently on a Renal Diet. Dietician "M" further revealed R46 often orders items that are not on the Renal Diet. A review of the EMR did not reveal a care plan regarding non-compliance. A review of the facility's "Behavioral Care Services" policy revealed the following, "...6. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes, but is not limited to:...e. Care Plan development and implementation..."			
F0677	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to	F0677	Element 1: Cited Residents Resident R152 currently resides in the facility.	5/13/2025

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SS= D	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00151407 and MI00151269. Based on observation, interview, and record review, the facility failed to respond to call lights and provide activities of daily living care (ADLs) in a timely manner for one resident (R152) and eight confidential group residents, of thirteen residents reviewed for ADLs. Findings include: R152 On 4/14/25 at 9:40 AM, R152 was met in their room and interviewed regarding the care they received at the facility. R152 indicated they frequently wait a long time for assistance with care. R152 indicated they had been waiting for over an hour to have their brief changed this morning. R152's call light was observed to be on the floor by the bed out of reach of the resident. At 9:50 AM, an observation was made of staff entering R152's room with a breakfast tray, setting the breakfast tray on the resident's bedside table and exiting the room. On 4/15/25 at 9:38 AM, a follow-up visit was		The Facility failed to respond to call lights and provide activities of daily living care in a timely manner. Element 2: Like Residents Residents who reside in the facility have the potential to be impacted by the identified deficiency. The facility completed baseline audit to ensure residents call lights are being answered in a timely manner based on resident interviews and observation. Element 3: Education Staff will be educated on the facility call light policy to ensure call lights are answered in a timely manner. Element 4: Audit Administrator or designee will complete a random audit 7x a week for 4 weeks to ensure the call lights are answered in a timely manner according to facility policy based on resident interviews and observation. Element 5: Compliance The facility Administrator will be responsible for assuring substance compliance is attained through this plan of correction by 5/13/25 and for sustained compliance thereafter.	

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	conducted with R152. R152 indicated they had a wet brief and proceeded to activate their call light. From 9:38 AM, to 9:51 AM, R152's call light was observed to be activated and multiple staff walked by the resident's room with out answering the call light. At 9:51 AM, staff was observed to enter R152's room, deactivate the call light and exit the room. R152 was interviewed and confirmed the staff that deactivated the call light did not ask them if they needed assistance. R152 then reactivated their call light. At 9:56 AM, the Director of Nursing (DON) was observed to answer R152's call light. On 4/15/25 at 10:00 AM, the DON was interviewed regarding their expectations for staff regarding answering call lights and addressing ADL care needs. The DON indicated that call lights should be answered as soon as possible and the call light should be left on until the care need is met. A record review of R152's electronic medical record (EMR) revealed that R152 was admitted to the facility on 2/22/25 with diagnoses that included Respiratory failure and COPD (Chronic obstructive pulmonary disease) (Lung disease). R152's most recent minimum data set assessment (MDS) dated 2/28/25 revealed that R152 had a moderately impaired cognition, was frequently incontinent of urine, and was dependent			

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	upon staff for toileting. A review of resident council meeting notes for the months of December 2024 through March 2025 revealed multiple resident concerns related to lack of staff team work resulting in delayed ADL care, long call light wait times, and staff turning off call lights without addressing residents' needs. On 4/15/25 at 10:30 AM, a group meeting was conducted with eight confidential group residents and they were asked about care at the facility. The group indicated that when agency staff (contract staff hired by the facility to assist with providing care to the residents) was working, call lights were not answered and care was not provided timely. A review of a facility policy titled, "Call Light...Timely Response Issue Date: 8.16.2023" stated, "Guidance: Staff members who see or hear an activated call light are responsible for responding regardless of assignment. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Process:...Turn off call light when resident's request is met."			
F0693 SS= D	Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A	F0693	Element 1 It is the practice of the facility to ensure an appropriate amount of water flush is provided between administration of individual medications via peg tube. Element 2 Residents that receive medications via peg	5/13/2025

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	resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the appropriate amount of water flush was provided between administration of individual medications via a percutaneous endoscopic gastrostomy (PEG) tube (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), for one resident (R73) of four observed during medication administration. Findings include: On 04/15/25 at 9:09 AM, a medication administration via a PEG tube for R73 was observed with Licensed Practical Nurse (LPN) "E". LPN "E" was observed to prepare medications for R73, nine were crushed for administration via R73's PEG tube. The PEG tube was uncapped and the tip of an open graduated 50 milliliter (ml) syringe was placed into the opening. An initial water flush of between 30 and 40 milliliters (mls) was observed to be completed via gravity. (The orders indicated a flush amount of 20-30 ml.) Each of the nine medications had been placed into plastic 30 ml medication cup.		tube have the potential to be affected by this cited practice. R73 stated she was fine and that she always feels full, R 73 was offered to take her medications by mouth and stated she prefers her medication via peg. LPN E was educated on medication administration via peg tube. Element 3 The Interdisciplinary Team reviewed the policy and procedure on Enteral Tube Medication Administration and deemed it to be appropriate. Nursing was educated on Enteral Tube Medication Administration. Element 4 Nurse Educator/Designee will audit random nurses weekly x4 for proper medication administration via peg, then monthly x3. Results of audits will be taken through QA for further review and recommendations. Element 5 The Administrator will be responsible for sustaining compliance.	

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	The initial medication cup was filled with 20 - 30 mls of water and poured into the syringe, medication remained in the cup and an additional 20-30 ml of water was used to clear the contents of the medication cup. This medication was followed with an additional 20-30 mls of water. Each of the next three medications was flushed with an additional 20-30 ml of water. R73 then reported they were feeling full and may need to throw up. LPN "E" then paused and added the last five crushed medications to the 30 mls of water in the syringe and flushed with an additional 20-30 mls of water. Upon completion LPN "E" was asked about combining medications for administration and reported they do combine for some residents but combined administration had not been ordered for R73. On 04/15/25 at 4:46 PM, the LPN "Q" reported medications via a PEG are given one by one and flushed with five to ten milliliters of water inbetween medications. On 04/15/25 at 4:55 PM, Unit Manager LPN "B" reported PEG medications are crushed and administered one by one. 20-30 milliliters of water are used to flush before starting and five to ten milliliters is used to flush between medications. On 04/16/25 at 9:52 AM, the Director of Nursing (DON) reported on query the medications are generally administered one at a time via a PEG tube though medications may be combined on consult with the pharmacist and physician. The DON further reported the flush amount between medications was 5-10 ml, but would consult the policy. A review of the facility policy titled, "Medication-Enteral Tube Medication Administration" issued 09/12/23 revealed,			

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	"...dilute crushed medications with at least 30 ml of water (or prescribed amount)... If administering more than one medication, flush with 15 ml of water between medications (or prescribed amount)..."			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a medication error of less than five percent for one resident (R73) of five residents reviewed for medication observation, resulting in a medication error rate of 12.82%. Findings include: On 04/15/25 at 9:09 AM, a medication administration for R73 via a percutaneous endoscopic gastrostomy (PEG) tube (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) was observed with Licensed Practical Nurse (LPN) "E". LPN "E" was observed to prepare medications for R73, nine were crushed for administration via R73's PEG tube. The PEG tube was uncapped and the tip of an open graduated syringe was placed into the opening. An initial water flush of between 30 and 40 milliliters (mls) was observed to be completed via gravity. The next four medications were followed with an additional 20-30 mls of water. R73 then reported they were feeling full and may need to throw up. LPN "E" then paused and added the last five crushed medications all together into the 30 mls of water in the syringe and flushed with an additional 20-30 mls of	F0759	Element 1 It is the practice of the facility to be Free of Medication Error Rates of 5 % Element 2 Residents that receive medications via peg tube have the potential to be affected by this cited practice. R73 stated she was fine and that she always feels full, R 73 was offered to take her medications by mouth and stated she prefers her medication via peg. LPN E was educated on medication administration via peg tube. Element 3 The Interdisciplinary Team reviewed the policy and procedure on Medication error and deemed it to be appropriate. Nursing was educated on Medication Errors and Medication Administration Via PEG Element 4 Nurse Educator/Designee will audit random nurses weekly x4 for proper medication administration via peg, then monthly x3. Results of audits will be taken through QA for further review and recommendations. Element 5 The Administrator will be responsible for sustaining compliance.	5/13/2025

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	water. Residual medication was observed to have been left in the syringe. Upon completion LPN "E" was asked about combining medications for administration and reported they do combine for some residents but combined administration had not been ordered for R73. On 04/16/25 at 9:52 AM, the Director of Nursing (DON) reported on query the medications are generally administered one at a time via a PEG tube though medications, but may be combined on consult with the pharmacist and physician. A review of the facility policy titled, "Medication-Enteral Tube Medication Administration" issued 09/12/23 revealed, "...dilute crushed medications with at least 30 ml of water (or prescribed amount)... Administer each medication separately... ..."			
F0760 SS= D	Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f) (2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00152118. Based on observation, interview, and record review, the facility failed to ensure the blood pressure medication (Clonidine) for one resident (R73) of one resident reviewed was administered as needed per physician order Findings include: On 04/15/25 at 9:09 AM, a medication pass observation for R73 was conducted with Licensed Practical Nurse (LPN) "E". Prior to the pass of medication LPN "E" checked the blood pressure of R73. The blood pressure (BP)was documented as 197/96 and a heart rate of 71. LPN "E"	F0760	Element 1 It is the practice of the facility that Residents are Free of Significant Medication Errors and to ensure the PRN blood pressure medication (Clonidine) is administered as needed per physician orders. Element 2 Residents that receive PRN Clonidine have the potential to be affected by this cited practice. R73 was seen and evaluated at bedside on 4/11/25 & 4/14/25 by physician for hypertension and refusal of medication. Element 3 The Interdisciplinary Team reviewed the policy and procedure on Medication Administration and deemed it to be appropriate. Nursing was educated on PRN blood pressure medication administration and to recheck blood pressure within 1 hour. If SBP is greater than 160 to call the physician.	5/13/2025

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	reported they would need to report this to the physician and upon review observed the active physician order dated 04/09/25, "Clonidine .1 mg (milligram), give one tablet via a percutaneous endoscopic gastrostomy (PEG) tube (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) every six hours, PRN (as needed) for hypertension (high BP). Administer for SBP (systolic BP) greater than 160 and notify physician." LPN "E" administered the clonidine. A review of the previous blood pressures (BP) documented a blood pressure of 196/88 at 5:00 AM on the same morning. A review of the vitals tab in the electronic medical record revealed the next blood pressure was taken by Nurse "E" at 9:20 AM. A review of the April 2025 Medication Administration Record (MAR) revealed two previous administrations of the PRN clonidine on April 9th and 12th, 2025 (BP 171/71 by LPN "E"). No additional administrations were documented on the MAR. A further review of the April MAR and physician's orders documented for additional blood pressure medications: Hydralazine scheduled at 6 AM, 2 PM and 10 PM; Furosemide, a water pill, scheduled at 6 AM which was refused on 04/14/25 and 04/15/25; and Carvedilol at nine AM and nine PM. Refusal of the furosemide was not documented in the progress notes as having been reported to the physician. A review of the April 2025 progress notes revealed no documentation of physician notification by the nurse related to the 5 AM blood pressure.		Element 4 UM/Designee will audit resident who have PRN blood pressure medication to ensure they are given appropriately weekly x4 then monthly x3. Results of audits will be taken through QA for further review and recommendations. Element 5 The Administrator will be responsible for sustaining compliance.	

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	A 04/09/25 progress note timed at 1:33 PM documented the as needed clonidine order from the physician and to call the physician if the as needed clonidine had to be administered. On 04/16/25 at 1:56 PM, the blood pressures in the electronic medical record for R73 were reviewed with Unit Manager "H". Ten or more blood pressures greater than 160 systolic were documented since the order was initiated. Some of these were noted to have a recheck with a similar value. The Unit Manager reported the expectation was to administer the as needed clonidine as ordered and report out of parameter blood pressures to the physician for review of the prescribed medication regimen. A review of the record revealed R73 was admitted into the facility on 12/10/24. Diagnoses included, Stroke, Heart Disease, Chronic Kidney Disease and Malnutrition. The Minimum Data Set (MDS) assessment dated 03/17/25 documented moderately impaired cognition and the need for partial/moderate assistance for most activities of daily living. A review of the National Institute for Health site at [www.nhlbi.nih.gov/health/high-blood-pressure] revealed, "...Blood pressures are written as two numbers separated by a slash like this: 120/80 mm Hg. You can say this as "120 over 80 millimeters of mercury" or just as "120 over 80." The first number is your systolic pressure - that ' s the force of the blood flow when blood is pumped out of the heart. The second number is your diastolic pressure, which is measured between heartbeats when the heart is filling with blood... A healthy systolic blood pressure is less than 120 mm Hg. A healthy diastolic pressure is less than 80 mm Hg. Your blood pressure is high when you have consistent systolic readings of 130 mm Hg or higher, or diastolic readings of 80 mm Hg or			

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	higher. Contact your provider immediately and ...Hypertensive Crisis: Higher than 180 systolic pressure or higher than 120 diastolic pressure, Contact your provider immediately."			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to discard expired, label with resident identifier and date when opened biologicals in three of four medications carts and one of four medication rooms reviewed. Findings include:	F0761	Element 1 It is the practice of the facility to ensure proper labeling of drugs and biologicals. The glucose strips, insulins and inhalers that were not dated and that did not have patient identifiers on them were removed from the med carts and discarded. Element 2 Residents who have eye drops, insulins and inhalers have the potential to be affected by this cited practice. Those residentsinhalers, insulins and eyedrops the medication carts were checked for proper label and dating. No other issues were found. Element 3 The Interdisciplinary Team reviewed the policy and procedure titled: Storage and Expiration Dating of Medications/Biologicals was reviewed and deemed appropriate. The nurses and Nurse Managers were inserviced on the proper labeling and dating of medications and biologicals. Element 4 U.M/or designee will audit all medication carts weekly x 4 weeks to ensure eye drops, inhalers and insulins are properly labeled and dated as needed and then monthly x 3 months. Results of audits will be taken through QA for further review and recommendations. The Administrator will be responsible for sustaining compliance.	5/13/2025

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	On 04/15/25 at 8:50 AM, the three Jefferson high medication cart was observed with Licensed Practical Nurse (LPN) "P". A dorzolamide eye drop vial was not labeled with a resident identifier nor date opened; glucose strips were not dated when opened; two insulin aspart vials were dated 3/10 and 3/05 and expired; A Basalgar insulin pen was not dated when opened; Two Trelegy inhalers were not dated when opened; and a Arnuity inhaler was not dated when opened on the inhaler and did not have an identifier on the inhaler. On 04/15/25 at 4:46 PM, the two Jefferson medication room was observed with LPN "Q". A tuberculin vial was open, but not dated. On 4/16/2025 at 9:44 AM an observation of the medication cart for revealed Latanoprost Eye drops laying outside of the box, without an identifying label or open date on the bottle. A further observation revealed a bottle of Prednisone Acetate in a box without an identifying label or open date on the bottle. On 04/16/25 at 9:52 AM, the Director of Nursing (DON) reported expired medication are to be discarded and a dated opened and identifier applied to medications that require them. A review of the facility "Prescription Dating/Storage Guidelines" effective 03/01/18 revealed, "...insulin lispro: vial expires 28 days after opening or removal from the refrigerator whichever comes first... Tuberculin: Discard vial in use after thirty days... latanoprost: may be stored at room temperature for up to six weeks."			

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	A review of the prescribing and manufacturer's information at [https://gskpro.com] revealed, "...Safely throw away Trelegy Ellipta in the trash 6 weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler." A review of the prescribing and manufacturer's information at [https://arnuity.com] revealed, "...Arnuity Ellipta should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard Arnuity Ellipta 6 weeks after opening the foil tray or when the counter reads "0" (after all blisters have been used), whichever comes first..."			
F0800 SS= F	Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure meal portion sizes met the nutritional needs of the residents, resulting in the potential for inadequate protein intake, weight loss, and decreased meal enjoyment. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 4/14/25 at 11:15 AM, Dietary Cook "O" was observed serving food at the steam table. Dietary Cook "O" was observed ladling chili into bowls	F0800	Element 1: Cited Residents The facility failed to ensure meal portion sizes meet the nutritional needs of the residents. No specific residents were affected by these practices. Element 2: Like Residents Residents who reside in the facility have the potential to be impacted by the identified practice. The facility audited the serving ladles to ensure they are the proper size. Element 3: Education Dietary Director and Dietary staff will be educated on the acceptable ladle size of 8 oz. to ensure the serving size meets the nutritional needs of the residents. Element4: Audits The administrator or designee will complete random audits on the kitchen tray line 5 meals a week for 4 weeks to on the acceptable ladle size of 8oz being used to ensure the serving	5/13/2025

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	with a 6 ounce ladle. When queried about the portion size for the chili, Dietary Cook "O" stated "Is this not right?" On 4/14/25 at 11:20 AM, review of the production sheet for the lunch meal, noted that the portion size for the chili was supposed to be 8 ounces. When queried at that time, Certified Food Manager "D" confirmed that Dietary Cook "O" was using the wrong size ladle. On 4/15/25 at 10:30 AM, a group meeting was conducted with eight confidential group residents and they were asked about the food at the facility. All group members indicated that food portions could be larger. Examples from the group included being served one individual rib when ribs were served for dinner recently and being served one slice of pizza during another recent dinner.		size meets the nutritional needs of the residents. Element 5: Compliance The facility Administrator will be responsible for assuring substance compliance is attained through this plan of correction by 5/13/25 and for sustained compliance thereafter.	
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F0812	Element 1: Cited Residents The facility failed to prepare food in accordance with professional stands for food service safety. No specific residents were affected by these practices. Element 2: Like Residents Residents who reside at the facility have the potential to be impacted by the identified practice. • FDS or designee will ensure that the ice scoop holder is free of debris. • FDS or designee will ensure the ice machine filter is clean and free from debris. • FDS or designee will ensure the interior of the microwave is clean and free from debris. • FDS or designee will ensure the flooring of the walk-in cooler is clean and free from debris. • FDS or designee will ensure spray bottles are appropriately labeled.	5/13/2025

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	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 from the kitchen. Findings include: On 4/14/25 during an initial observation of the kitchen between 8:45 AM-9:15 AM, the following items were observed: The ice scoop holder was observed with black debris on the inside bottom surface. The tip of the ice scoop was resting in the black debris. When queried, Certified Food Manager (CFM) "D" stated she would clean it right away. According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: ...(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food)..." The ice machine filter was observed to be dusty. When queried, CFM "D" provided no explanation. According to the 2017 FDA Food Code		• FDS or designee will ensure the floor drain cover underneath the dich machine is clean and free from debris. • FDS or designee will ensure to properly test and document the dish machine. • Housekeeping Supervisor or designee will ensure the nourishment rooms on 2nd and 3rd floor are clean and free from debris. Element 3: Education Dietary staff and Housekeeping staff will be educated on the importance of appropriate and effective methods of cleaning in all areas and the sanitation policy. Element 4: Audits The FDS or designee will complete a random audit 5x a week for 4 weeks for cleanliness compliance. The Housekeeping Supervisor will complete a random audit 3x a week for 4 weeks for nourishment room cleanliness. Element 5: Compliance The facility Administrator will be responsible for assuring substance compliance is attained through this plan of correction by 5/13/25 and for sustained compliance thereafter.	

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	section 4-602.13 Nonfood-Contact Surface, "Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues." The interior of the microwave was observed with splattered, dried on food debris. CFM "D" confirmed the soiled microwave, but provided no further explanation. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, "(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." In the walk-in cooler, the flooring was soiled with large areas of black stains, and there was dried up milk pooled on the floor underneath the milk crates. CFM "D" confirmed the soiled floors and stated she would have staff mop the floors right away. 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." In the chemical room/janitor's closet, there were 2 unlabeled spray bottles on the shelf, filled with a clear liquid. CFM "D" stated "I think it's just water", but provided no explanation for why the bottles were not			

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	labeled. According to the 2017 FDA Food Code section 7-102.11 Common Name, "Working containers used for storing POISONOUS OR TOXIC MATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material." The floor drain cover underneath the dish machine was completely obstructed and coated with debris and dirt. 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." On 4/14/25 at 9:15 AM, the low temperature/chemical sanitizing dish machine was observed. The log for the dish machine was observed hanging on the wall near the dish machine. It was noted that the log had not been completed since breakfast on 4/11. CFM "D" confirmed that the dish machine should be checked for sanitization daily, 3 time a day (breakfast, lunch, dinner). When queried about the test strips used to check the sanitizer level in the dish machine, CFM "D" pointed to a container of quaternary ammonia test strips, which were attached to the dish machine log. The dish machine was observed with a bottle of chlorine sanitizer attached. When queried about the availability			

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	of chlorine test strips, CFM "D" stated she would check to see if they had any. A plate simulator sent through the dish machine registered a maximum temperature of 140 degrees Fahrenheit. This surveyor used their own chlorine test strips to test the level of chlorine sanitizer in the dish machine. The strip did not change color to denote the presence of chlorine sanitizer. CFM "D" stated she would contact a repair company. According to the FDA Food Code section 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization-Temperature, pH, Concentration, and Hardness, "A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under §7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart; P". According to the 2017 FDA Food Code section 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration, "Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device." On 4/14/25 at 9:30 AM, the 2nd floor			

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	nourishment room was observed. The interior surfaces of the microwave had areas of peeling paint, and the cabinet underneath the sink was observed with 2 towels that had been spread out over the surface. The "white" towels were stained black with a mold-like substance. On 4/14/25 at 9:35 AM, the 3rd floor nourishment room was observed. The microwave was rusty on the inside top surface and along the front bottom edge. The bottom shelf underneath the sink was observed with water damage and was soiled with a black, mold-like substance.			
F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i)	F0880	Element 1 It is the practice of the facility to ensure appropriate infection control practices are used for equipment cleaning. The Nursing and Housekeeping staff were educated on cleaning of the tube feed pole and spills on the floor. Element 2 Residents that have a peg tube pole in the facility have the potential to be affected by this citied practice. Residents' rooms with a tube feeding pole were audited and cleaned. Element 3 The Interdisciplinary Team reviewed the policy and procedure titled: Cleaning and Disinfection of Resident-Care Equipment was reviewed and deemed the policies to be appropriate. Nursing and Housekeeping will continue to be educated on this policy. Element 4 Environmental Manager/designee will randomly audit on residents with tube feeding poles to ensure there are no spills on the floor	5/13/2025

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	A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a tube feeding (TF) pole in a sanitary manner for one sampled resident (R128) of one reviewed for tube feeding sanitation. Findings Include:		or pole itself for 4 weeks and then monthly x 3 months. Results of audits will be taken through QA for further review and recommendations. The Administrator will be responsible for sustaining compliance.	

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	On 4/14/25 at 2:10 PM, R128 was observed lying in bed with their tube feeding in place noting a bag of Isosource 1.5 cal missing the resident's name, date, time, or order. The tube feeding pole and base were observed to have a very thick layer of brown dried tube feed stuck to it. Also noted were a pair of used gloves on the floor. A review of R128's medical record revealed they were admitted into the facility on 6/7/24 with diagnoses of Hemiplegia and Hemiparesis following a Cerebral Infarction, Dysphagia, and Diabetes. Further review revealed the resident was severely cognitively impaired and was dependent on enteral feed for nutrition. On 4/15/25 at 8:59 AM, R128's tube feeding pole was observed to have a thick layer of brown tube feeding fluid stuck to it. In addition, there was a pool of wet fluid observed on the floor. On 4/16/25 at 10:50 AM, R128's tube feeding pole was observed to have a thick layer of brown tube feeding fluid stuck to it. On 4/16/25 at 1:04 PM, the Infection Control Preventionist was asked her expectation for the cleanliness of tube feeding poles and explained the pole should be cleaned when observed as soiled. A review of the "Cleaning and Disinfection of Resident-Care Equipment" policy revealed the following, "...3. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include...e. for durable medical equipment, such as feeding pumps, staff shall store used/dirty equipment in soiled utility room..." Resident Call System §483.90(g) Resident	F0919	Element 1: Cited Residents	5/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	4/16/2025

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F0919 SS= D	Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that call lights were in reach for three residents (R57, R106, R152) of four residents reviewed for call light accessibility. Findings include: R57 On 4/14/25 at 9:15 AM, an observation was made of R57's call light being on the floor by the side of the bed, out of reach of the resident. On 4/15/25 at 9:27 AM, an observation was made of R57's call light being on the floor, by the bed, out of reach of the resident. R57 was interviewed regarding the location of their call light and stated, "I don't know." A record review was completed of R57's electronic medical record (EMR) and revealed that R57 was admitted to the facility on 2/18/25 with diagnoses that included Atrial fibrillation (Irregular heart rate) and Heart disease. R57's most recent minimum data set assessment (MDS) dated 2/24/25 revealed		Residents R57, R106, and R152 currently reside in the facility. Facility failed to ensure that call lights are in reach. Element 2: Like Residents Residents who reside in the facility have to the potential to be impacted by the identified deficiency. The facility completed a baseline audit to ensure residents had call lights in place. Element 3: Education Staff will be educated on the importance of ensuring the call lights are within reach for residents. Element 4: Audit Administrator or designee will complete a random audit on 10 residents a week for 4 weeks to ensure their call light is in place. Element 5: Compliance The facility Administrator will be responsible for assuring substance compliance is attained through this plan of correction by 5/13/25 and for sustained compliance thereafter.	

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	that R57 had an intact cognition and required substantial assistance to being dependent for all activities of daily living (ADLs) other than eating. R106 On 4/14/25 at 9:39 AM, an observation was made of R106's call light being on the floor, under the bed, out of reach of the resident. On 4/16/25 at 9:54 AM, R106's call light was observed to be on the floor next to the bed, out of reach of the resident. While the surveyor was in the room with R106, Licensed Practical Nurse (LPN) "C" entered the room and was asked where R106's call light should be located. LPN "C" picked up the call light off of the floor and clipped it to R106. On 4/16/25 at 10:08 AM, LPN "B" was interviewed regarding their expectations regarding call light placement in residents' rooms. LPN "B" indicated the call light should be clipped to or located beside the resident within their reach. A record review of R106's EMR revealed that R106 was admitted to the facility on 12/22/22 with diagnoses that included Respiratory failure and Muscle weakness. R106's most recent MDS dated 3/21/25 revealed that R106 had moderately impaired cognition and required moderate assistance to being dependent for all ADLs other than eating.			

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	R152 On 4/14/25 at 9:40 AM, R152's call light was observed to be on the floor by the bed, out of reach of the resident. A record review of R152's EMR revealed that R152 was admitted to the facility on 2/22/25 with diagnoses that included Respiratory failure and COPD (Chronic obstructive pulmonary disease) (Lung disease). R152's most recent MDS dated 2/28/25 revealed that R152 had a moderately impaired cognition, was frequently incontinent of urine, and was dependent upon staff for toileting. On 4/16/25 at 1:19 PM, the Administrator (NHA) was interviewed regarding their expectations for placement of call lights in residents' rooms. The NHA indicated all staff should be checking that call lights are in place and accessible to the resident. A review of a facility policy titled, "Call Light Accessibility... Issue Date: 8.16.2023" stated, "Guidance: Staff will be educated...ensuring residents have access to the call light. Staff will ensure the call light is...within reach of residents...The call system will be accessible to residents while in their room at bedside..."			