| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235549 | A. Building<br>B. Wing | 07/03/2024 |

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| F 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056<br><br>Based on interview and record review, the facility failed to ensure that the activated medical and financial Durable Power of Attorney (DPOA) was accurately recorded in the medical record for 1 of 6 residents (Resident #24) reviewed for advance directives, resulting in the potential for inappropriate delegation of resident rights to a person not formally authorized to make decisions on behalf of the resident.<br><br>Findings include:<br><br>Resident #24 (R24):<br><br>Review of an Admission Record revealed R24 was an [AGE] year-old female, admitted to the facility on [DATE]. Family Member (FM) L was listed as R24's POA (Power of Attorney)-Health Care and Primary Financial Contact.<br><br>Review of R24's Advance Directive documentation revealed that R24 had been deemed incompetent by 2 physicians and R24's Designated POA's for medical and financial decisions were granted authority to make all financial and medical decisions on behalf of R24.<br><br>Review of R24's Durable Power of Attorney for Financial Matters documentation revealed FM N was appointed to make financial decisions for R24. FM L was listed as a substitute agent and would be responsible for financial decisions if FM N was unable or unwilling to act.<br><br>Review of R24's Durable Health Care Power of Attorney documentation revealed FM O and FM P were appointed to make medical decisions for R24. FM L was not listed.<br><br>During an interview on 07/01/24 at 03:44 PM, FM L reported that he was not R24's legal Power of Attorney but worked together with his 2 sisters and brother in regards to her healthcare decisions and financial decisions/responsibilities. FM L confirmed he was not R24's POA but was her emergency contact. FM L reported that his brother was the financial POA and his 2 sisters were the medical POA.<br><br>Review of R24's Progress Note dated 04/05/2024 revealed, . New order obtained to increase Norco to 1 tablet by mouth every 4 hours as needed .(FM L) DPOA notified of this via voicemail . Indicating R24's healthcare appointed POA was not notified of a change in health status/medication change.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R24's Progress Note dated 05/04/2023 revealed, SSD (Social Services Director) updated resident's son (FM L) about how resident is doing in facility. (FM L) requested monthly care conferences for over the phone updates on his mom .<br><br>During an interview on 07/03/24 at 10:57 AM, Social Worker (SW) C reported that the process for residents with a DPOA was to ensure the contact information for each DPOA was documented in the Electronic Health Record and on the Admission Record/Facesheet. If a resident had more than 1 DPOA or had a separate DPOA for financial and medical decisions, that would be specified on the Admission Record/Facesheet to ensure the appropriate person was contacted.<br><br>Review of the facility policy Advance Directives last reviewed 01/2024 revealed, The policy of the facility is to ensure our residents have the right to request, refuse and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate advance directive .Advance Care Planning: a process used to identify and update the resident's preference regarding care and treatment at a future time including a situation in which the resident subsequently lacks capacity to do so .Durable Power of Attorney for Health Care (i.e., Medical Power of Attorney): a document delegating authority to a legal representative to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated .2. Social Services or designee will ask each resident or representative if they have previously formulated an advance directive upon admission. If so, Social Services will request from the resident or representative a copy of the advance directive to be placed in the resident's medical record. This action is to take place on admission and documented in resident's medical record .<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, The Patient Self-Determination Act (PSDA, 1991) requires health care institutions to provide written information to patients concerning their rights to make decisions about their care, including the right to refuse treatment and to formulate an advance directive. A patient's record must indicate whether a patient has signed an advance directive and include a copy of the directive if it is available. Patients must also be offered information about advance directives. An advance directive is a document developed by patients that instructs others to do tasks before, during, and after their death. At a minimum, an advance directive includes a statement of a patient's wishes if a respiratory or cardiac arrest occurs and a copy of the patient's durable power of attorney for health care (DPAHC). [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 330). Elsevier Health Sciences. Kindle Edition. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577<br><br>Based on observation, interview, and record review, the facility failed to accommodate the needs of 3 out of 3 residents reviewed ( Resident #10, Resident #4, and Resident #18) and several reported unmet needs at the Resident Council Meetings, when staff did not assist a resident to get out of bed throughout the day, did not consistently offer and pass out evening snacks or fresh water on each shift, and by not answering call lights in a timely manner.<br><br>Findings:<br><br>Resident #10 (R10):<br><br>Review of a Face Sheet revealed R10 was [AGE] year old male, admitted to the facility on [DATE], with pertinent diagnoses of a stroke causing left sided weakness and paralysis and blindness in right eye. R10 requires assist from two staff persons to transfer out of bed.<br><br>During an observation on 07/01/24 at 9:38 AM, R10 laid in bed with eyes open and TV on.<br><br>During an observation on 07/01/24 at 12:40 PM, R10 laid in bed with eyes closed. R10 was uncovered, had a tee shirt pulled up over the umbilicus and wore only a brief. There were no activity items in the room such as books or puzzles.<br><br>During an observation on 07/01/24 at 1:51 PM, R10 laid in bed with eyes open and television off.<br><br>During an interview on 07/01/24 at 2:00 PM, Certified Nurse Aide (CNA) H stated that staff had not gotten R10 out of bed yet today. We really haven't had the time.<br><br>During an observation on 07/01/24 at 4:18 PM, R10 laid in bed with eyes open and television off.<br><br>During multiple observations throughout the day on 07/02/24, R10 laid in bed and the television was off.<br><br>During an observation on 07/03/24 at 7:45 AM, R10 laid in bed with eyes closed and the television off.<br><br>During an observation on 07/03/24 at 11:02 AM, R10 laid in bed with eyes open and the television was off.<br><br>During an observation on 07/03/24 at 1:08 PM, R10 laid in bed with eyes closed and the television off.<br><br>During an interview on 07/03/24 at 1:59 PM, CNA K indicated that staff had not gotten R10 out of bed at all today.<br><br>During an observation on 07/03/24 at 3:05 PM, R10 laid in bed with eyes open and the television off.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R10's Progress Notes dated 02/13/24 to present, revealed documentation that R10 was out of bed on the following days for the following reasons: 02/13/24 out to a gastroenterology (stomach) appointment, 02/27/24 out to a urology (bladder) appointment, 03/13/24 out to a nephrology (kidney) appointment, 03/17/24 and 03/30/24 were identical notes written by the same nurse and indicate R10 was up in a chair and in the family room, and 04/14/24 up in chair in family room as family was here to see him. There are no progress notes that reflect R10 being out of bed after 04/14/24 for purposeful and meaningful activity.<br><br>Review of R10's Care Plans included the following interventions for staff to utilize: (1) encourage participation in facility life to promote friendship ad positive distractions, (2) activity staff will assist R10 during programs, (3) adjust activities to accommodate R10's energy level and tolerance, (4) assist R10 with locating a favorite TV show or channel as needed, (5) R10 enjoys going outside, listening to music, being around others, watching TV/movies etc, (6) offer R10 a variety of materials such as books, magazines, puzzles, coloring books, cards, etc, (7) staff will assist R10 to and from activities, (8) vary the physical environment when able such as going outdoors when weather permits, (9) encourage R10 to attend and participate in activities that suit his interests or of his choosing, (10) introduce R10 to other resident's and staff, (11) offer R10 choices when able and appropriate in attempt to help him feel that he still has some control over his care<br><br>Resident Council:<br><br>Review of Resident Council Minutes dated 08/15/23 reflected the following concerns: (a) still having to ask for evening snacks, just not being passed out and (b) third shift call light response time is slow.<br><br>Review of Resident Council Minutes dated 09/19/23 reflected the following concerns: (a) evening snacks-we will educate staff again on passing them out and (b) third shift call light response time is slow.<br><br>Review of Resident Council Minutes dated 10/17/23 reflected the following concerns: (a) third shift call light response time is slow.<br><br>Review of Resident Council Minutes dated 11/14/23 reflected the following concerns: (a) second shift call light response time is slow after dinner.<br><br>Review of Resident Council Minutes dated 12/12/23 reflected the following concerns: (a) morning water pass has gotten slow.<br><br>Review of Resident Council Minutes dated 01/16/24 reflected the following concerns: (a) morning water pass is slow and (b) problems with second shift call light response time.<br><br>There were no Resident Council Minutes for a meeting in February 2024.<br><br>Review of Resident Council Minutes dated 03/22/24 reflected the following concerns: (a) one resident reported waiting an hour for the call light to be answered, (b) another resident reported putting on her call light after another resident was out in the hallway looking for help and could not find staff, and (c) water pass is sporadic.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident Council Minutes dated 04/23/24 reflected the following concerns: (a) second shift water pass is slow.<br><br>Review of Resident Council Minutes dated 05/21/24 reflected the following concerns: (a) water pass is really slow all shifts.<br><br>Review of Resident Council Minutes dated 06/18/24 reflected the following concerns: (a) snacks not being passed, they have to ask for them, (b) call lights are hit or miss depends on who is working-second shift is hard to get help after dinner, and (c) water is still not being passes timely.<br><br>39056<br><br>Resident #4 (R4):<br><br>Review of an Admission Record revealed R4 was an [AGE] year-old female, admitted to the facility on [DATE].<br><br>Review of a Minimum Data Set (MDS) assessment for R4, with a reference date of 5/25/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R4 was cognitively intact.<br><br>During an observation on 07/01/24 at 08:03 AM, R4 was in bed in her sleepwear.<br><br>During an observation on 07/01/24 at 09:16 AM, R4 was in bed in her sleepwear.<br><br>During an interview on 07/01/24 at 12:40 PM, R4 was sitting up in her recliner finishing her lunch. R4 reported that she had concerns with call light wait times and reported it could take up to an hour for her call light to be answered. R4 reported the facility staff not only wouldn't answer the call light, but they would not check in with her to let her know that there would be an extended wait time and stated the facility staff always have an excuse for not promptly assisting her. R4 stated, sometimes I have an emergency and need help (bathroom) and there's nobody here to help me which caused her feelings of frustration and helplessness. R4 stated this morning nobody got me up or cleaned me up and reported that her preference was to get up and dressed prior to breakfast which was what normally occurred. R4 reported she had to eat breakfast in bed that morning.<br><br>Resident #18 (R18):<br><br>Review of an Admission Record revealed R18 was an [AGE] year-old female, admitted to the facility on [DATE].<br><br>Review of a Minimum Data Set (MDS) assessment for R18, with a reference date of 4/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated R18 was cognitively intact.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/01/24 at 09:19 AM, R18 reported the facility Certified Nursing Assistants (CNA) are abrupt, not friendly, have bad attitudes, and stated I don't know if they'll be nice or not nice during their shift. R18 stated, they (CNA's) just don't care what your needs are during the day and it almost feels like you're in prison. R18 reported that the call light wait times are consistently an hour but can exceed an hour and has felt as though I was the only one in the building.<br><br>R18 reported the CNAs do not round throughout the day and stated, you cannot find anybody after 6:30 (PM). R18 reported that from 6:30 PM to midnight the call light wait time is significantly longer and it is difficult to find staff and stated, they hide somewhere, they have to, they aren't on the floor. R18 reported that the second shift staff had the worst attitudes and care and felt there was a sufficient number of staff but felt that there was no work ethic.<br><br>R18 reported that staff do not consistently pass waters and with each meal she would have to ask for a fresh water.<br><br>Review of the facility policy Standards of Nursing Practices last reviewed 01/2024 revealed, .Call Light Response-Staff with respond to residents request for assistance by answering call lights within a reasonable amount of time. it is considered that a reasonable period to arrive to the residents request for assistance is no longer than a 10-minute period of time. it is understood that response time may be delayed due to emergency events, unplanned urgent resident occurrences in which could cause a delay in responses. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>37573<br><br>Based on interview and record review, the facility failed to provide Advance Beneficiary Notices (ABN) and the Notice of Medicare Non-Coverage (NOMNC) for 3 Residents (Resident #12, Resident #19, Resident #40) of 3 residents reviewed for notifications.<br><br>Findings include:<br><br>On 7/1/24 during entrance conference a request was made for a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months.<br><br>On 7/1/24 at 2:10 PM, an email correspondence was sent the Nursing Home Administrator (NHA) to provide the ABN and NOMNC notifications for three residents (R12, R19, and R40) who were chosen from the list provided.<br><br>In an interview on 7/1/24 at 3:22 PM, the NHA and Social Worker (SW) C reported they did not have an ABN or NOMNC for the residents selected.<br><br>Review of a Policy Provided by the facility revealed:<br><br>Purpose: To abide by the Social Security Act and protect beneficiaries and [Facility] from unexpected liability for charges associated with claims that Medicare does not pay, and for the purpose of informing the Medicare beneficiary, (Medicare Fee-For-Service (FFS) Part A) that Medicare certainly or probably will not pay for them on the particular occasion. The SNF will issue the Advance Beneficiary Notice (CMS form 10055, Skilled Nursing Facility Advance Beneficiary Notice, SNFABN). (Section 40.3). In addition, to inform the beneficiary of his or her right to an expedited review, the SNF will also issue the Notice of Medicare Non-Coverage (CMS Form # 10123 NOMNC). |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>37577<br><br>Based on observation, interview, and record review, the facility failed to maintain an environment free of fall hazards and high hot water temperatures.<br><br>Findings include:<br><br>During an observation on 07/01/24 at 3:32 PM the clean utility/pantry room was unlocked and accessible to any self-mobile resident. The room contained an unsecured 19 ounce aerosol spray can of Array disinfectant cleaner. Two feet inside the room and in the walkway, laid two thick black rubber mats, approximately 3' x 4' in size, that were folded on top of each other and stood 6 inches off the ground.<br><br>During an observation on 07/03/24 at 8:50 AM, Maintenance Director E and Laundry Supervisor I worked in the resident hallway, outside the clean utility/pantry room, cleaning a 3 tier plastic cart that had been stored in the room. On the floor of the resident hallway, just outside the door, sat the two folded black rubber mats. Laundry Supervisor I worked on the left side of the hallway and the black rubber mats sat on the floor on the right side of the hallway, creating a funnel pathway in the center of the hallway, so that two people could not walk down the hallway side by side. Multiple observations were made of staff and resident's stopping on either side of the funnel pathway and waiting for another person to pass through. A few observations were made of staff simply stepping over the pile of folded black rubber mats. During an observation on 07/03/24 at 9:13 AM the folded black rubber mats remained on the floor in the resident hallway just outside the clean utility/pantry room while Laundry Supervisor I continued cleaning the 3 tier plastic cart. On 07/03/24 at 9:18 AM Laundry Supervisor I removed the 3 tier plastic cart and left the resident hallway. The folded black rubber mats remained in the hallway. 10 different staff were observed walking past the folded black rubber mats and did not stop to move them. On 07/03/24 at 9:33 AM Laundry Supervisor I returned and removed the folded black rubber mats from the resident hallway.<br><br>38905<br><br>During a tour of the facility, at 11:35 AM on 7/1/24, it was found that the hot water from the central spa hand sink was found to reach 123.9F when tested with a rapid read thermometer.<br><br>An interview with Maintenance Director (MD) E, at 11:40 AM on 7/1/24, found that he takes hot water temperatures in the morning and there is multiple hot water systems in the building. One servicing the west end, one for the east end, and one for the kitchen. When asked what hot water system supplies the Central spa room, MD E stated it was the west end water heater.<br><br>Observation of the water heater for the west end of the building, at 11:46 AM on 7/1/24, found that the water heater goes through a mixing valve before supplying care areas on the floor. At this time, the thermometer showed outgoing water at 120F and MD E adjusted the mixing valve to help lower the temperature.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a tour of the dining room, at 9:33 AM on 7/2/24, it was observed that the hot water to the sink was found to reach 126.8F with a rapid read thermometer. Observation under the sink found that it had a point of use mixing valve to help temper the water at the sink. It was found that this sink is provided hot water off of the kitchens domestic hot water supply, but is provided with a point of use mixing valve that needs to be adjusted. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577<br><br>Based on observation, interview, and record review, the facility failed to follow standards of practice for two residents (Resident #10 and Resident #25) receiving hydration and nutrition through a feeding tube.<br><br>Findings include:<br><br>Resident #10 (R10):<br><br>Review of a Face Sheet revealed R10 was [AGE] year old male, admitted to the facility on [DATE], with pertinent diagnoses of a stroke causing left sided weakness and paralysis and blindness in right eye. R10 received all hydration and nutrition through a tube feeding.<br><br>During an observation on 07/01/24 at 9:38 AM the syringe and plastic basin used to flush the tube feed were dated 06/24/24 and the plunger was stored inside the syringe and not separated out to dry properly.<br><br>During an observation on 07/01/24 at 12:38 PM, R10's tube feed hung with a kangaroo flush bag that did not have the resident's name, a date or time indicating when it was started, nor the ordered rate.<br><br>Review of the facility policy Tube Feeding last reviewed 01/2024 revealed: formula and flush bags are to be labeled when hung by nursing. This should include resident name, date/time started, and the physician ordered rate and volume to be infused.<br><br>39056<br><br>Resident #25 (R25):<br><br>Review of an Admission Record revealed R25 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral infarction (stroke).<br><br>Review of R25's Order Summary dated 5/8/24 revealed, Osmolite 1.2 @ 25cc/hour x 18 hours (5 PM-11 AM) for a total volume of 450 cc.<br><br>Review of R25's Care Plan revealed, Category: Nutritional Status (R25) is as Nutritional / Hydration risk r/t (related to) receives 100% of nutrition and hydration via feeding tube . Approach Start Date: 10/06/2023 Elevate HOB (head of bed) minimum of 30 degrees or as<br><br>ordered.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 07/01/24 at 09:16 AM, R25 was in bed on her back with her tube feeding running. The head of her bed was at 21 degrees. R25's tube feed was hung with a kangaroo flush bag. The formula bag had a date written on the bag bud did not have the resident's name or time indicating when it was started, nor the ordered rate.<br><br>During an observation on 07/02/24 at 08:03 AM, R25 was in bed on her back with her tube feeding running. The head of her bed was at 24 degrees.<br><br>During an observation on 07/03/24 at 07:44 AM, R25 was in bed on her back with her tube feeding running. The head of her bed was at 21 degrees.<br><br>Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, Keep the head of the bed elevated a minimum of 30 degrees, preferably 45 degrees, unless medically contraindicated, during feedings and for 30 to 60 minutes after feeding ([NAME] et al., 2017). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1122). Elsevier Health Sciences. Kindle Edition. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573<br><br>Based on observation, interview and record review, the facility failed to 1.) Properly store medications in 1 of 2 medication carts and in 1 of 2 medication storage rooms and 2.) Ensure that a resident's medications were securely stored in a medication cart for one resident (Resident #18).<br><br>Findings include:<br><br>During an observation and interview on [DATE] at 10:30 AM, Licensed Practical Nurse (LPN) A had a medication cart at the end of the hallway with 7 open bottles of artificial tears in the carts, 5 of the bottles were opened with no dates indicating when they were opened, one bottle had an opened date of [DATE] and the other bottle had an opened dated of [DATE]. Two bottles of Moisture Eye drops, 1 bottle of Fluconazole nasal spray, 1 bottle of Azelastine nasal spray, a bottle of liquid Famotidine which was opened, and 2 bottles of Dorzolamide eye drops, with no opened dates or proper labeling on the bottles were located inside the medication cart. Also located inside the cart was a large spray bottle with clear liquid and not labeled. LPN A reported the medications should have the opened dates written on them and should not be used. LPN A thought the spray bottle was hand sanitizer.<br><br>During an observation and interview on [DATE] at 11:36 AM, the medication storage room near the front nursing station had a medication refrigerator that stored insulins and other medications with a temperature of 32 degrees. The temperature log sheet was last completed on [DATE]. There was an 8-ounce bottle of liquid multivitamin that expired ,d+[DATE] and a bottle of Cherry flavored liquid acetaminophen that expired , d+[DATE]. LPN B reported she did not know what the temperature of the refrigerator should be and acknowledged the 2 bottles of medications were expired.<br><br>Review of a policy titled 5.3 Storage and Expiration Dating of Medications, Biological's last revised [DATE] revealed 10. Facility should ensure that medications and biological's are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility Staff should monitor the temperatures of vaccines twice a day. 10.2 Refrigeration: 36 degrees - 46 degrees F (Fahrenheit) or 2 degrees - 8 degrees C (Celsius).<br><br>Review of a document provided by the facility revealed IV. MAINTENANCE OF MEDICATION STORAGE AREAS: A. CART: 6. Expiration dates are to be monitored with medication usage. 7. Insulins, eye [drops], saline solutions multi dose are to be dated on date opened. B. MED ROOM: 4. Refrigerators used for medication storage must have a thermometer monitoring ideal temps ,d+[DATE] degrees F (unless otherwise specified). Adjust refrigerator setting until thermometer register is appropriate. Refrigerators with vaccines stored in them require monitoring and recording of temperature 2x/day (two times a day). C. PATIENT/RESIDENT ROOM: 2. Living areas should be free of drugs brought in from any source. No solutions/creams/OTCs (over the counter) at bedside, and no medication at bedside without physician's order may keep at bedside in patient's/resident's orders.<br><br>39056<br><br>Resident #18 (R18):<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of an Admission Record revealed R18 was an [AGE] year-old female, admitted to the facility on [DATE].<br><br>Review of a Minimum Data Set (MDS) assessment for R18, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated R18 was cognitively intact.<br><br>Review of R18's Physician Order dated [DATE] revealed, Restasis (cyclosporine) dropperette; 0.05 %; Administer 1 drop to both eyes two (2) times a day.<br><br>During an observation and interview on [DATE] at 09:19 AM, R18's nightstand had 3 unused/unopened dropperettes (single use plastic eye drops) of cyclosporine 0.05% (Restasis). R18 reported she did not know why the facility nurses left the eye drops in her room and reported she did not administer the eye drops to herself. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905<br><br>Based on interview and record review the facility failed to offer additional food preferences, and alternative or optional food choices for two residents (Resident #4 and Resident #18) of six residents interviewed.<br><br>Findings include:<br><br>An interview with Dietary Supervisor (DS) G at 11:58 AM on 7/1/24, found that menus are posted on the hallway and changed everyday. When asked what options are available for meal service, DS G stated there is a main entree option and the alternate menu for residents to choose from. When asked how residents make choices about what they would like, DS G stated that residents usually tell a nursing staff member who would relay that to the kitchen. When asked if facility staff takes regular orders from residents, DS G stated the kitchen would go by the residents preferences, likes, and dislikes, unless the resident tells us otherwise. A review of the Alternate Meal Choices menu posted outside of the dinning room stated Please let the kitchen know by 11 AM for lunch and 2 PM for Dinner.<br><br>An interview with Confidential Staff Q, at 8:30 AM on 7/2/24, found that some items on the alternative menu don't seem to be regularly available. The salad sandwich, hamburger are not available and I couldn't even get a peanut butter and jelly sandwich today as they only have crunchy peanut butter.<br><br>39056<br><br>Resident #4 (R4):<br><br>Review of an Admission Record revealed R4 was an [AGE] year-old female, admitted to the facility on [DATE].<br><br>Review of a Minimum Data Set (MDS) assessment for R4, with a reference date of 5/25/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R4 was cognitively intact.<br><br>During an interview on 07/01/24 at 12:40 PM, R4 reported that the facility food was lousy and cold and reported there was very little variety with the meals that were served and with alternative meals.<br><br>Resident #18 (R18):<br><br>Review of an Admission Record revealed R18 was an [AGE] year-old female, admitted to the facility on [DATE].<br><br>Review of a Minimum Data Set (MDS) assessment for R18, with a reference date of 4/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated R18 was cognitively intact.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/01/24 at 09:19 AM, R18 reported that there was little variety with the meals that were served and reported that they were served a dinner with pork on a Sunday and then variations of the pork leftovers were served Monday, Tuesday, and Wednesday. R18 reported that if the main meal wasn't accepted an alternative would be provided, however, hot dogs are starting to be the only alternate meal. R18 reported that recently she did not want the lunch and was provided a hotdog and was then given 2 hotdogs as the alternate for dinner. R18 reported the other alternate meal was peanut butter and jelly sandwich and both the hotdog and peanut butter and jelly sandwich were not suitable for residents that had difficulty with chewing and/or swallowing.<br><br>R18 reported that she had asked for an alternate meal after her lunch was served and was told by a kitchen staff member that if we want an alternative we have to ask before 11 (AM) and stated the kitchen staff member told me they cant cater to us, there's a production line. R18 reported frustration and stated, sometimes I don't know I don't want it (the meal) until I see it. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>38905<br><br>Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.<br><br>Findings Include:<br><br>During an initial tour of the kitchen, starting at 9:03 AM on 7/1/24, it was observed that the top portion of the door seals of the two door Traulson freezer were found with an increased accumulation of crumb and dirt debris and shown to Dietary Supervisor (DS) G.<br><br>During a revisit to the kitchen, at 8:02 AM on 7/2/24, it was observed that the top portion of the door seals of the two door Traulson freezer were found with an increased accumulation of crumb and dirt debris.<br><br>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.<br><br>During the initial tour of the kitchen, at 9:29 AM on 7/1/24, it was observed that the internal thermometer inside of the two door Raetone refrigeration unit read 30F. A product temperature of a whole intact tomato was taken and found to be 45.5F. At this time, DS G placed a new thermometer in the unit and stated staff have been getting in and out of the unit which could be why the temperature is high. When asked when the units temperature was checked last, DS G stated the temperature was good this morning, but was read off of the questionable thermometer. Further evaluation of the unit found the left door seal was loose on the top section, and would not properly seal when the door was closed. When the door was closed, light could seen from inside of the unit through the door seal . DS G stated he would reach out and get someone onsite to look at the unit and would try and turn the unit up.<br><br>During a revisit to the kitchen, at 10:25 AM on 7/1/24, observation of the thermometers in the Raetone two door cooler read 30F and 45F. Another product temperature was taken from a whole tomato and found to be 45F.<br><br>During a revisit to the kitchen, at 7:52 AM on 7/2/24, it was observed that the internal thermometer read 44F and the temperature of a butter packet was found to be 46F. When asked if any food product had been moved from the unit or discarded at this point, DS G stated no.<br><br>During a revisit to the kitchen, at 11:58 AM on 7/2/24, an interview with the Vendor repairing the Raetone refrigeration unit, found it was low on Freon and started to have some icing on the thermostat (which tells the unit when to kick on). At this time, Dietitian F stated that potentially hazardous food from the unit had been discarded and other products were moved. Observation at this time found the unit empty.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | According to the 2017 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C ) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less.<br><br>During a tour of the hallway utility pantry, at 10:08 AM on 7/1/24, it was observed that some items were found open with no date to indicate discard or held past the discard date. These items were: An open container of thickened water with a manufactures discard of seven days after opening with no discard date, a tray of peanut butter and jelly sandwiches with no discard date, an open container of shrimp with a date of 6/23/24, a cup of mashed potatoes dated 6/22/24, and a container of BBQ takeout with no date. At this time, when asked how often dietary staff come down and stock the unit, DS G stated someone comes down every day. When asked how long resident food from outside the facility is kept, Dietitian F stated three days.<br><br>According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (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 .<br><br>According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .<br><br>During a revisit to the kitchen, at 8:21 AM on 7/2/24, it was observed that a bowl of eight frozen nutritional drinks were laying in a bowl full of water in the rinse compartment of the three-compartment sink. DS G stated the water should be running and turned the faucet back on to run water into the bowl. At this time, a half full box of frozen nutritional drinks and box of nutritional ice cream was sitting on the cart in ambient air outside of the refrigeration unit or freezer.<br><br>According to the 2017 FDA Food Code section 3-501.13 Thawing.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 5C (41F) or less; or (B) Completely submerged under running water: (1) At a water temperature of 21C (70F) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5C (41F) . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056<br><br>This citation has two Deficient Practice Statements (DPS)<br><br>DPS 1:<br><br>Based on interview and record review, the facility failed to 1) Implement a system to prevent, recognize, and control the onset and spread of infection among residents for 3 residents (Resident #33, Resident #37, and Resident #21) and 2) Investigate, document surveillance of, and implement preventative measures to address an outbreak of a respiratory illness among staff and residents.<br><br>Findings include:<br><br>Review of the [DATE] Resident Infection Control Log revealed 2 residents were listed due to the use of antibiotics. There was no other tracking related to residents with infectious symptoms.<br><br>Review of the Electronic Health Record revealed 3 additional residents were identified as being prescribed antibiotics in the month of [DATE] and were not accounted for on the Resident Infection Control Log.<br><br>Resident #33 (R33):<br><br>Review of an Admission Record revealed R33 was a [AGE] year-old male, admitted to the facility on [DATE].<br><br>Review of R33's Order Summary revealed:<br><br>ceftriaxone recon soln (reconstitute solution); 2 gram;Once A Day Infuse IV q24hrs at 100ml/hr. Start Date [DATE] - [DATE].<br><br>vancomycin recon soln; 25 mg/mL; Every 6 Hours. order for 19 days, first dose ,d+[DATE]. Start Date [DATE] - [DATE]<br><br>Review of R33's McGeer Criteria dated [DATE] revealed R33 was diagnosed with clostridium difficile (a highly contagious infection causing diarrhea. This infection requires transmission based precautions).<br><br>Review of R33's McGeer Criteria dated [DATE] revealed R33 was diagnosed with osteomyelitis.<br><br>Resident #37 (R37):<br><br>Review of an Admission Record revealed R37 was a [AGE] year-old male, admitted to the facility on [DATE].<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of R37's Order Summary revealed, cephalexin capsule; 500 mg; Four times daily x 7 days. Start Date [DATE] - [DATE]. The order did not include an indication for use per the Antibiotic Stewardship Program policy.<br><br>During an interview on [DATE] at 1:48 PM, DON reported that R37 was on antibiotics for post-surgical prophylaxis.<br><br>Resident #21 (R21):<br><br>Review of an Admission Record revealed R21 was a [AGE] year-old male, admitted to the facility on [DATE].<br><br>Review of R21's Order Summary revealed, cephalexin capsule; 500 mg; Once A Day x 10 days for cellulitis of right foot. Start Date [DATE] - [DATE].<br><br>During an interview on [DATE] at 11:50 AM, DON reported the IPCP had inadequate surveillance and tracking and confirmed the Resident Infection Control Log did not accurately reflect the residents with infection and/or antibiotic use.<br><br>On [DATE] at 1:00 PM a request for the outbreak investigation from the COVID-19 outbreak in February/[DATE] was requested. On [DATE] at 7:00 PM a Word Document was received and revealed the following:<br><br>*7 staff members were listed with the date they tested positive. The document did not include the last date they worked or contact tracing (process of quickly identifying, assessing, and managing people who have been exposed to a disease to prevent additional transmission).<br><br>*5 residents were listed with the date they tested positive. The document did not include contact tracing.<br><br>*The document did not include the date and time the Medical Director was notified of the outbreak.<br><br>*The document did not include the date and time the Health Department was notified of the outbreak.<br><br>*The document did not include the date and time the staff and residents were notified of the outbreak.<br><br>*The document did not include the date and time the family/emergency contacts/guardians were notified of the outbreak.<br><br>*The document did not include interventions implemented to prevent the spread of COVID-19 in the facility (transmission-based precautions, increased cleaning, staff and resident education, restriction of movement between units, laboratory testing).<br><br>*The document did not include daily active surveillance of all residents and staff for illness.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on [DATE] at 11:37 AM, DON confirmed that an outbreak investigation had not been completed at the time of the COVID-19 outbreak. DON confirmed that the ICP did not complete an Outbreak Management Checklist.<br><br>During an interview on [DATE] at 8:46 AM, Nursing Home Administrator (NHA) reported that a copy of the outbreak investigation was not provided to him and reported if one was completed, DON would have a copy available. Per the Facility Assessment and the Outbreak Identification and Management policy, documentation from an outbreak was to be reviewed and analyzed in QAPI (Quality Assurance and Performance Improvement).<br><br>Review of the Facility Assessment last reviewed [DATE] revealed, .3.11. Roosevelt Park Nursing & Rehabilitation Community evaluates the infection prevention and control program to include effective systems 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, that follow accepted national standards. Our infection Control Preventionist maintains a tracking and surveillance for all potential infectious and communicable diseases by infection and unit. Decisions are made regarding care and prevention based on the disease and overall needs. We discuss this daily (Monday-Friday) in our clinical AM review and again during monthly QAPI committee meeting .Infection Control S483.80(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: (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 S483.70(e) and following accepted national standards.<br><br>Review of the facility policy, Outbreak Identification and Management last reviewed ,d+[DATE] revealed, Policy: This policy is intended to provide guidance in identifying an outbreak timely, measures to take in the event of an outbreak to reduce the spread of infection, when to notify the medical Director/Resident Physician/Local health Department, recording outbreak occurrences and completing a review of the occurrence with needed corrective action(s) related to the incidents of illness attributing to the outbreak . Respiratory symptoms and illness: If one laboratory-confirmed positive case of illness is identified along with other cases of similar acute illness in a unit of a long-term care facility, an outbreak might be occurring. Active surveillance for additional cases should be implemented as soon as possible once one case of laboratory-confirmed illness is identified in a facility. When 2 cases of laboratory-confirmed illness are identified within 72 hours of each other in residents on the same unit, outbreak control measures should be implemented as soon as possible. Implementation of outbreak control measures can also be considered as soon as possible when one or more residents have acute symptoms with suspected illness and the results of testing are not available the same day of specimen collection .Measures to take in the event of an outbreak-Once an outbreak has been identified the following actions should be taken in the facility to reduce the spread of illness. Actions taken should be documented with date and time completed.<br><br>*Alert all facility staff to the outbreak: reinforce use of standard precautions and good hand hygiene.<br><br>*Implement Transmission based precautions as applicable for all symptomatic residents (this includes suspected and confirmed).<br><br>(continued on next page) |

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| | 235549 | A. Building<br>B. Wing | 07/03/2024 |

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| Roosevelt Park Nursing and Rehabilitation Communit | 1300 W Broadway Ave<br>Muskegon, MI 49441 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | *Contact the resident's physician/Medical Director.<br><br>*Conduct laboratory testing to determine organism and confirm illness.<br><br>*Implement daily active surveillance of all residents and staff for illness.<br><br>*If applicable, contact pharmacy to confirm adequate supplies of vaccine, medications, etc.<br><br>*If applicable, re-offer vaccine to any staff or resident not yet vaccinated.<br><br>*If applicable, institute antiviral chemoprophylaxis for residents as indicated.<br><br>*Keep residents with confirmed and suspected illness together and away from other residents.<br><br>*Restrict staff movements among units/floors.<br><br>*Educate residents on hand hygiene and other control measures as applicable.<br><br>*Notify local health department using state specific reporting timeframe requirements upon outbreak recognition. Determine if the health department wants clinical specimens.<br><br>*Notify family members and receiving facilities of the outbreak. Visitations will be allowable with end of life or upon review by the facility's Infection Control Preventionist.<br><br>*Ensure that resident rooms and common areas are cleaned more frequently .<br><br>*Initiate a resident and employee log (line listing) of illness. Additions to the log should be completed at the time of onset of symptoms to ensure real-time tracking and trending .<br><br>Outbreak analysis and review-All measures taken and documentation from an outbreak will be reviewed and analyzed for areas that were done well and areas that have opportunity for improvement to ensure best practices were used in managing the outbreak. The outbreak will then be reviewed in Quality Assurance and Performance Improvement (QAPI) and if needed areas of improvement are identified an action plan will be created.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the facility policy, Infection Control Program last reviewed ,d+[DATE] revealed, .Elements of an Infection Control Program-The success of this Infection Control Program is base as (sic) facility-wide effort involving all disciplines and individuals, it should also be considered an integral part of the facility's overall quality assurance and performance improvement program, and have the active support of the administration, residents, families, clinical, support staff, and attending physicians. The elements of an infection control program consist of; *coordination/oversight *policies/procedures *surveillance *antibiotic stewardship program *outbreak management *prevention of infection * employee health and safety .This Infection Control Program contains components under which it-1. Investigates, controls, and prevents infections in the facility 2. Decides what procedures, such as isolation, should be applied to an individual resident 3. maintains a record of incidents and corrective actions related to infections .Coordination and Oversight-The Director of Nursing has the responsibility of coordination and oversight of the Infection Control Program. The Director of Nursing may appoint a clinical staff person with interest and additional training in infection prevention and control to assist in the coordination and oversight of the Infection Control Program. The duties of an Infection preventionist may include .*Surveillance activities *Monitoring tracking systems, collecting and analyzing data .*Helping manage outbreaks and acting as a liaison with public health agencies .*Ensuring that relevant information is transmitted to appropriate individuals .All infections are tracked and to be logged regularly . Surveillance-Surveillance refers to a system for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Prevention and treatment begin with recognizing the kinds of infections that occur and the signs and symptoms of their onset. Infections among the residents are not always obvious. Therefore, medical criteria and standardized definitions of infections are needed to help recognize and manage infections, Atrium with utilize McGeer's criteria to assist in the recognition of infections and ensure antibiotic usage is appropriate as part of their Stewardship program. Additional resources may be utilized to support quality Antibiotic Stewardship .Outbreak Management-Infectious outbreaks are infrequent but can be potentially devastating. The two most likely and potentially most dangerous categories of epidemics and outbreaks are respiratory infections (such as influenza and COVID-19) and gastrointestinal infections .Atrium support staff will guide and assist as necessary the facility in compliance with pertinent state and local regulations concerning the reporting and management of those with reportable communicable diseases .<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the facility policy Antibiotic Stewardship Program last revised ,d+[DATE] revealed, 1. The Infection Preventionist serves as the leader of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility. a. Infection Preventionist-coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff. b. Director of Nursing or designee-serves as back up coordinator for antibiotic stewardship activities, provides support and oversight, and ensures adequate resources for carrying out the program .4. The program includes antibiotic use protocols and a system to monitor antibiotic use. A. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection and notify the physician. ii. Laboratory testing shall be in accordance with current standards of practices. iii. The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections. iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use .b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made .ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness .<br><br>38905<br><br>During a tour of the nursing storage room, at 11:22 AM on [DATE], it was observed that clean and sanitary nursing items were found on the floor. These included a box full of tracheostomy care items, shower caps, mouth swabs, and a box full of 18 bottles of tube feeding (14 of which were expired and 4 that were still within their expiration date).<br><br>During a tour of the soiled utility room, at 11:33 AM on [DATE], it was observed that the room had an open hopper with no easily accessible gloves, gowns, or masks to be used. When asked if he was able to find any in the room, Maintenance Director E stated he couldn't find them in the room.<br><br>During a tour of the facility, at 1:49 PM on [DATE], it was observed that the compartment under the activities sink was found stocked with activity items. These items were being stored under the sinks wastewater line and would be subject to possible contamination.<br><br>DPS 2:<br><br>Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing.<br><br>Findings include:<br><br>During a tour of the facility, with Maintenance Director E, at 1:26 PM on [DATE], it was asked if staff regularly use the hopper in the soiled utility room. MD E was unsure if staff use the hopper routinely. At this time, the water in the hopper bowl was found heavily evaporated and sunk down into the basin of the hopper. When the hot water was turned on to the fixture over the hopper, brown water was dispensed for a few seconds then turning clear. When asked if he ever flushes water out of the hopper, MD E stated he has not.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with MD E at 1:55 PM on [DATE], it was found that the facility has a flushing list for some fixtures, but currently does not test or have control limits for anything regarding the domestic water supply. When asked if MD E would meet with anyone to go over the plan, he was unsure, when asked if there was a water management team, MD E was unsure.<br><br>A review of the facilities Water Pathogen Risk Reduction policy, not dated, found that, Each facility will assign a water management team, and that the Water Management Team will meet at least quarterly and will consist of the following representatives: Facility Leadership-Administrator, Infection Control Coordinator/Preventionist, Facility water treatment service provider representative, Quality Assurance Performance Improvement Committee members. Once established, The Water Management team will review the initial completed risk assessment and then follow-up monitoring findings to identify risk factors for Legionella. Further review found, a plan for how to monitor the water system will be developed. This will follow the recommended control limits with adjustments made as needed by the water management team. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056<br><br>Based on interview and record review, the facility failed to ensure that residents who required an antibiotic were prescribed the appropriate antibiotic for 3 of 6 residents (Resident #142, Resident #143, and Resident #144) reviewed for antibiotic use, resulting in inappropriate antibiotic utilization and the potential for antibiotic resistance.<br><br>Findings:<br><br>Resident #142 (R142):<br><br>Review of an Admission Record revealed R142 was an [AGE] year-old female, admitted to the facility on [DATE].<br><br>Review of R142's Order Summary revealed Cipro (ciprofloxacin hcl) tablet; 500 mg; and 250 mg; (Total of 750mg) Twice A Day. Start Date 03/27/2024 - 04/08/2024<br><br>Review of R142's Electronic Health Record revealed no culture and sensitivity report (to ensure the antibiotic ordered was effective in treating the bacteria).<br><br>Resident #143 (R143):<br><br>Review of an Admission Record revealed R143 was a [AGE] year-old male, admitted to the facility on [DATE].<br><br>Review of R143's Order Summary revealed, cephalexin (Keflex) 500 mg tablet Four Times A<br><br>Day from 4/28/24-5/1/24.<br><br>Review of R143's Laboratory Report resulted on 4/28/24 (the date R143 was admitted to the facility) revealed the organisms (bacteria) from R143's urinary tract infection were not susceptible to Keflex.<br><br>Review of R143's History and Physical (physician note) dated 4/30/24 revealed, .Urinary tract infection, was started on Keflex in the hospital, sensitivity indicate sensitive 2 cipro. Will change to Cipro . Confirming R143 was on an antibiotic that was ineffective in treating the urinary tract infection.<br><br>Review of R143's Order Summary revealed, Cipro (ciprofloxacin hcl) 500 mg tablet Twice A Day from 5/1/24-5/5/24.<br><br>Review of the May 2024 Resident Infection Control Log revealed R143 was documented as having a UTI with no culture obtained and no organism identified.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/03/02024 at 11:50 AM, DON reported that the culture and sensitivity report should have been reviewed upon admission and the provider should have been notified of the results. DON confirmed the delay in treatment.<br><br>Resident #144 (R144):<br><br>Review of an Admission Record revealed R144 was a [AGE] year-old male, admitted to the facility on [DATE].<br><br>Review of R144's Order Summary revealed, Cipro (ciprofloxacin hcl) 500 mg tablet Every 12<br><br>Hours from 5/18/24-5/24/24.<br><br>Review of R144's Electronic Health Record revealed no culture and sensitivity documentation.<br><br>Review of the May 2024 Resident Infection Control Log revealed R144 was documented as having a UTI with no culture obtained and no organism identified.<br><br>During an interview on 07/03/02024 at 11:50 AM, DON confirmed that the ICP did not obtain the culture and sensitivity report from R144's hospital stay. DON reported that they need to improve on antibiotic stewardship and confirmed the antibiotic stewardship program required closer monitoring to ensure appropriate antibiotic utilization and to prevent the risk of antibiotic resistance.<br><br>During an interview on 07/03/02024 at 1:03 PM, DON reported she was unable to locate a copy of R142 and R144's culture and sensitivity reports in the Electronic Health Records.<br><br>Review of the facility policy Antibiotic Stewardship Program last revised 09/2022 revealed, 1. The Infection Preventionist serves as the leader of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility. a. Infection Preventionist-coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff. b. Director of Nursing or designee-serves as back up coordinator for antibiotic stewardship activities, provides support and oversight, and ensures adequate resources for carrying out the program .4. The program includes antibiotic use protocols and a system to monitor antibiotic use. A. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection and notify the physician. ii. Laboratory testing shall be in accordance with current standards of practices. iii. The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections. iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use .b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made .ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness .<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy, Infection Control Program last reviewed 01/2024 revealed, . Surveillance-Surveillance refers to a system for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Prevention and treatment begin with recognizing the kinds of infections that occur and the signs and symptoms of their onset. Infections among the residents are not always obvious. Therefore, medical criteria and standardized definitions of infections are needed to help recognize and manage infections, Atrium with utilize McGeer's criteria to assist in the recognition of infections and ensure antibiotic usage is appropriate as part of their Stewardship program. Additional resources may be utilized to support quality Antibiotic Stewardship . |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>39056<br><br>Based on interview and record review, the facility failed to ensure that a qualified Infection Preventionist worked at least part-time at the facility, was provided sufficient time to perform the Infection Preventionist role, and was present to properly assess, implement, and manage the Infection Prevention and Control Program.<br><br>Findings include:<br><br>Review of the Facility Assessment last reviewed May 2024 revealed the following the Director of Nursing was listed as the Infection Control Preventionist.<br><br>.3.11. Roosevelt Park Nursing & Rehabilitation Community evaluates the infection prevention and control program to include effective systems 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, that follow accepted national standards. Our infection Control Preventionist maintains a tracking and surveillance for all potential infectious and communicable diseases by infection and unit. Decisions are made regarding care and prevention based on the disease and overall needs. We discuss this daily (Monday-Friday) in our clinical AM review and again during monthly QAPI committee meeting .Infection Control S483.80(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: (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 S483.70(e) and following accepted national standards.<br><br>The Facility Assessment did not determine the amount time designated to the ICP to complete the duties of the IPCP per the facility policy Role of the Infection Preventionist.<br><br>During an interview on 07/02/2024 at 9:20 AM, Director of Nursing (DON) reported that Infection Control Preventionist (ICP) A was certified in infection prevention and control and also worked full time as a floor nurse at the facility; 4 days 1 week and 5 days the following week. DON reported that she had been completing infection control surveillance and outcome surveillance for residents and staff when ICP A was unavailable and/or working the floor and ICP A would sign off on the documentation. DON reported that she had not completed specialized training in infection prevention and control and had been working on completing the certification.<br><br>During an interview on 07/03/2024 at 8:17 AM, Nursing Home Administrator (NHA) reported that ICP A worked as a Licensed Practical Nurse full-time at the facility as a floor nurse and took over the Infection Prevention and Control Program (IPCP) beginning on 5/24/24 when the previous ICP left the facility. NHA reported that ICP A was not scheduled to work on 7/3/24 or 7/4/24 and was not available to review the IPCP in person or by telephone. NHA reported that DON was responsible for covering the IPCP when ICP A was not onsite/available.<br><br>(continued on next page) |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/03/2024 at 11:33 AM, DON reported that ICP A was the previous ICP's backup but took over the ICP role approximately 5 weeks ago when the previous ICP left. DON reported that ICP A did not have designated time to maintain/monitor the IPCP due to working full time on the floor but did have some time after 1st and 2nd medication pass to perform the ICP duties. DON reported that ICP A did not have set hours or set days for assessing, developing, implementing, monitoring, and managing the IPCP.<br><br>Review of the IPCP revealed that an outbreak investigation had not been completed for a COVID-19 outbreak in February-March 2024, 3 residents on antibiotics were not identified and/or tracked on the June 2024 Resident Infection Control Log, and 3 residents were administered antibiotics without confirming the antibiotic was effective in treating the strain of bacteria identified on a culture and sensitivity report.<br><br>During an interview on 07/03/02024 at 11:50 AM, DON reported the IPCP had inadequate surveillance and tracking and confirmed the Resident Infection Control Log did not accurately reflect the residents with infection and/or antibiotic use.<br><br>DON reported that they need to improve on antibiotic stewardship and confirmed the antibiotic stewardship program required closer monitoring to ensure appropriate antibiotic utilization and to prevent the risk of antibiotic resistance.<br><br>DON confirmed that the ICP did not complete an outbreak investigation during the COVID-19 outbreak in February-March 2024. The DON was unable to provide an outbreak report or a completed Outbreak Management Checklist.<br><br>(continued on next page) |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy Role of the Infection Preventionist last reviewed 01/2024 revealed, Policy: The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program .1. The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program. 2. The facility will ensure the Infection Preventionist is qualified by education, training, experience or certification .4. The IP will have the knowledge to perform the role and remain current with infection prevention and control issues and be aware of national organizations' guidelines, as well as those from national/state/local public health authorities .6. The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its IPCP. Designated IP hours per week may vary based on the facility and its resident population. 7. The facility, based upon the facility assessment, will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA .9. The IP must be sufficiently trained in infection prevention and control. Specialized training in infection prevention and control may include care for residents with invasive medical devices, resident care equipment (e.g., ventilators), and treatment such as dialysis as well as high-acuity conditions. If the facility's resident population changers, the IP may need to obtain additional training for the change in the facility's scope of care, based upon re-evaluation of the IP's knowledge and skills. 10. The IP must have obtained specialized IPC training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate(s) of completion or equivalent documentation. Specialized training should include the following topics: a. Infection prevention and control program overview; b. Infection preventionist's role; c. Infection surveillance; d. Outbreaks; e. Principles of standard precautions .f. Principles of transmission-based precautions; g. Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing); h. Water management; i. Linen management; j. Preventing respiratory infections (e.g., influenza, pneumonia); k. Tuberculosis prevention; l. Occupational health considerations (e.g., employee vaccinations, exposure control plan, and work exclusions); m. Quality assurance and performance improvement; n. Antibiotic stewardship; and o. Care transitions. 11. The Infection Preventionist reports to the Director of Nursing. 12. Responsibilities of the Infection Preventionist include but are not limited to: a. Develop and implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment. b. Establish facility-wide systems for prevention, identification, reporting, investigation and control of infections and communicable disease of residents, staff and visitors. c. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control. d. oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program. ed. Oversight of resident care activities .f. Review and/or revise the facility's infection prevention and control program, its standards, policies and procedures annually and as needed for changes to the facility assessment to ensure they are effective and in accordance with current standards of practice for preventing and controlling infections .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235549 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roosevelt Park Nursing and Rehabilitation Communit | 1300 W Broadway Ave<br>Muskegon, MI 49441 |

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

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the State Operations Manual revealed, IP (Infection Preventionist) Hours of Work- Designated IP hours per week can vary based on the facility and its resident population. Therefore, the amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment, conducted according to S483.70(e), to determine the resources it needs for its IPCP, and ensure that those resources are provided for the IPCP to be effective. Based upon the assessment, facilities should determine if the individual functioning as the IP should be dedicated solely to the IPCP. A facility should consider resident census as well as resident characteristics, types of units such as respiratory care units, memory care, skilled nursing and the complexity of the healthcare services it offers as well as outbreaks and seasonality of infections such as influenza in determining the amount of IP hours needed. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905<br><br>Based on observation and interview the facility failed to maintain general cleanliness and repair of the premises. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living for all residents.<br><br>Findings include:<br><br>During a tour of the Utility Pantry, at 10:08 AM on 7/1/24, with Dietary Supervisor G and Dietitian F, it was observed that the cabinets were found to be deteriorating and falling apart from the base and underside of the unit. It was observed that water damage had occurred over time in the bottom of the cabinetry and had worn down surfaces. Further observation found a large hole in the wall behind a stainless-steel panel that was covering up plumbing between the ice machine and the cabinets. The stainless-steel cover did not seal the hole to minimize the entrance of pests.<br><br>During a tour of the facility, with Maintenance Director (MD) E, starting at 11:28 AM on 7/1/24, it was observed that the storage room containing nursing and tube feeding supplies, found excess debris, cardboard and paper trash, along with clean and sanitary items on the floor. Observation of the rooms' light shield found it half off the ballast and hanging down from one side. An interview with MD E found that he has been having a hard time finding the right light covers and will get them shielded with a clear tube for now.<br><br>During a tour of the service hall storage room, at 1:52 PM on 7/1/24, it was observed that a light shield cover was not present on the overhead lights.<br><br>Upon entering the facility, at 7:28 AM on 7/2/24, it was observed that a back portion of the roof and soffit was in disrepair and is leaving open access to the attic space.<br><br>During a tour of the facility, at 9:33 AM on 7/2/24, it was observed that the following wall mounted air conditioning (A/C) units on the hallways were found with an increased accumulation of black spotted debris: A/C by beauty salon, A/C by room [ROOM NUMBER], A/C by East Nurses station, A/C/ by room [ROOM NUMBER].<br><br>During an interview with NHA, at 10:00 AM on 7/2/24, regarding the back side of the building in poor repair on the roof and soffit, found that the facility is working on a solution, but there is no scheduled repair at this time.<br><br>During a perimeter tour of the facility, starting at 10:04 AM on 7/2/24, it was observed that a large dumpster and cardboard recycling container were found with their doors open allowing rain and pests to enter.<br><br>39056<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 07/01/24 at 03:36 PM, Family Member (FM) M reported that he had concerns with the condition of his loved one's room. FM M reported that on multiple occasions the bedside commode the resident was using was not cleaned causing the room to have a strong odor of urine and feces. On other occasions the bedside commode was left with urine and feces in it and the nursing staff didn't even know how to change it (empty it). FM M reported that on more than one occasion, the residents bedding was not changed and the linen was visibly soiled and malodorous. FM M reported that his concerns were voiced to management and they always promise it'll get better. It doesn't always, but sometimes it does. |