| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235349 | A. Building<br>B. Wing | 09/15/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Point Nsg & Phy Rehab Ctr of Ishpeming | 435 Stoneville Rd<br>Ishpeming, MI 49849 |

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35102<br><br>Based on observation, interview, and record review, the facility failed to ensure care plans were revised related to nutritional needs, wound care, antibiotic use, and hospice services for four Residents (#23, #32, #34, and #57) out of 12 residents reviewed for Care Plans. This deficient practice resulted in the potential for unmet needs and lack of coordinated care. Findings include:<br><br>Resident #32<br><br>According to the MDS Significant Change assessment, 7/22/2020, Resident #32 was admitted to the facility on [DATE] with the following major diagnoses: Alzheimer's disease, dementia, and depression. The same assessment indicated Resident #32 had no speech (absence of spoken words), was rarely/never understood nor understands, and had severely impaired cognition. Resident #32 was dependent on staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. The same assessment indicated one Stage III pressure ulcer (full thickness tissue loss) was not present upon admission/reentry.<br><br>Resident #32's wound care was observed on 9/3/20 at 10:40 a.m., with Wound Care/Licensed Practical Nurse (LPN) Z where Santyl ointment was applied to the wound base.<br><br>Review of Resident #32's Order Summary Report, printed 9/3/20, read in part, Apply Santyl (ointment) to wound bed and lightly fill dead space with AMD gauze. Cover with 3x3 (inch) silicone bordered foam dressing .<br><br>Review of Resident #32's Pressure Ulcer Care Plan, revised 8/20/20) read in part, .Apply 2x2 gauze soaked in hydrogel to wound bed .<br><br>Review of Resident #32's Comfort Care Plan, revised 4/17/20, read in part, Notify Hospice if pain is not relieved .<br><br>During an interview on 9/10/20 at 10:06 a.m., LPN Z confirmed Resident #32's Pressure Ulcer Care Plan was not updated in regards to the use of Santyl ointment instead of the previously ordered hydrogel solution. LPN Z said the treatment results were different. When asked about the Care Plan intervention for hospice, LPN Z said it was no longer applicable since hospice care ended 7/8/2020.<br><br>Resident #34<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to the MDS assessment, dated 7/24/20, Resident #34 was readmitted to the facility on [DATE] with the following applicable diagnoses: pneumonia, anemia, and chronic obstructive pulmonary disease. Resident #34 required one staff assistance for dressing, eating, toilet use, personal hygiene, and bathing. The BIMS score was 15 out of 15, which indicated intact cognition.<br><br>Review of Resident #34's Care Plan read in part, .is on antibiotic therapy (brand name medication) eye drops r/t (related to) red crusty eyes (initiated and revised 2/29/20) .<br><br>Review of Resident #34's current physician orders, 9/4/20, does not indicate antibiotic medication for an eye infections was ordered.<br><br>During an interview on 9/9/20 at 11:35 p.m., LPN Z confirmed she was the responsible staff for MDS assessments, Care Plans, and Wound Care.<br><br>40383<br><br>Resident #23<br><br>A review of Resident #23's medical record revealed an admitted [DATE], with diagnoses that included Alzheimer's disease, displaced fracture of hip, type 2 diabetes, and history of falling. Further review of Resident #23's record revealed physician orders on 7/13/20 which included Wander guard to left ankle, (a device which enables an alarm to sound to prevent elopement risks).<br><br>A progress note written and dated 7/13/2020 at 2:30PM read in part: Resident with confusion and is able to propel self in wheelchair. Has had a few attempts of attempting to exit facility. MD notified, Wander guard ordered . Wander guard placed to left ankle. Care plan updated.<br><br>The care plan for Resident #23 included the concern: . has behavior problem . dementia aeb (as evidenced by) wandering. Initiated on 07/08/2020. The care plan approaches included: Allow (Resident #23) for safe wandering . Place photograph on the wanders list .<br><br>On 09/09/20 at 9:02 AM, CNA H was asked about the wanders list. CNA H replied, I haven't checked them in a while. I know the nurse knows . CNA H was unsure where the wanders list was kept. The list was located in a three-ring binder, but Resident #23 was not in the binder. CNA H replied: (Resident #23) is one of the ones who wanders everywhere. CNA H reported the book was to show you who would get out of the building or wander . (Resident #23) is not in there. I would figure that she would be. She is a wanderer. Although the care plan included placing Resident #23 on the wanders list, this had not been done.<br><br>On 09/09/20 at 8:50 AM, Licensed Practical Nurse (LPN) Z stated Resident #23 was admitted with buttock pressure area and a deep tissue injury on her heel. Resident #23's care plan included: At risk for skin alteration r/t (with regards to) impaired mobility, recent right hip fx (fracture) with repair, muscle weakness, bowel incontinence, Alzheimer's. (Resident #23) was admitted with pressure injuries. Date Initiated: 06/25/2020 and is at risk for potential nutrition related problems secondary to anemia, type 2 DM, . Alzheimer's disease and stage II pressure ulcer on L (left) buttocks. Date Initiated: 06/27/2020. The care plan interventions included: Resident #23 is:<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - to receive an additional serving of protein-rich foods (meat/egg/dairy) c (with) meals. Date Initiated: 06/27/2020<br><br>- RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed). Date Initiated: 06/27/2020<br><br>- ST (Speech Therapist) rec. (recommendation) finger foods and individual bowl for each item Date Initiated: 07/08/2020<br><br>On 7/12/2020 at 4:44AM, a general nursing progress note revealed: res. (Resident #23) has been rattling her side rails a lot tonight. res. complained of being hungry and given a snack and drink. this made her feel better .<br><br>During meal rounds on 9/09/20 at 12:39 PM, Resident #23's tray was observed and included a slice of salisbury steak with gravy, broccoli and potatoes on a dinner plate. There were no finger foods or individual bowls given. Resident #23 did not receive an additional protein serving. These interventions were not included on Resident #23's tray card. On 8/31/20 at 11:08 PM RD B wrote a progress note referring to Resident #23's Stage III pressure ulcer R (right) heel 1.5 x 2.2 x <0.1cm (centimeters), the care plan interventions of finger foods, individual bowls and additional protein servings were not discussed.<br><br>Resident #57<br><br>A review of Resident #57's medical record revealed an initial admitted [DATE], with diagnoses that included Alzheimer's disease, mild intellectual disabilities, and type two DM. Further review of Resident #57's record revealed physician's orders dated 8/26/20 of Carbohydrate Controlled Diet, Mechanical Soft texture, Regular consistency.<br><br>Resident #57's care plan was reviewed and included:<br><br>- (Resident #57) needs to receive full assist with meals. Date Initiated: 05/28/2020<br><br>- Provide (Resident #57) with CCD (Carbohydrate Control Diet), Mechanical Soft diet with honey thick liquids as ordered. Date Initiated: 12/16/2016<br><br>During meal rounds on 9/09/20 at ~12:30 PM, Resident #57 had been served his tray and was observed at the far end of his room, with his back to the hallway eating alone and unassisted. The care plan approach of receiving full assist with meals was not followed.<br><br>On 9/9/20 at 9:19 AM, the Dietary Manager A stated Resident #57 was changed by the ST from a honey thick liquid to a regular consistency on 8/26/20. The record review revealed the current care plan had not been updated. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103<br><br>Based on observation, interview, and record review, the facility failed to provide grooming, personal care, and dining assistance for four dependent Residents (#4, #27, #32, and #47) of 12 residents reviewed for activities of daily living (ADLs). This deficient practice resulted in unmet nutritional and personal care needs. Findings include:<br><br>Resident #4:<br><br>During an observation on 9/3/2020 at 2:23 p.m., Resident #4's toenails were observed in the presence of Licensed Practical Nurse (LPN) Q. Resident #4's toenails were long, very thick, and appeared untrimmed. During an interview at this same time, when asked when the toenails were last trimmed, Resident #4 stated, I don't know - when I get my showers . Every now and then I get to have a shower. I don't know when they cut my toenails . LPN Q, present during the interview said she had trimmed Resident #4's toenails in the past, but stated, It has been awhile since I cut them.<br><br>Review of Resident #4's ADL Care Plan found no reference to needed assistance with nail care.<br><br>Resident #27:<br><br>Review of Resident #27's Minimum Data Set (MDS) assessment, dated 7/14/2020, revealed Resident #27 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (MS) and depression. Resident #27 scored 14 of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition, however Resident #27's spouse served as both medical and financial guardian for the Resident. Resident #27 required extensive, two-person assistance with bed mobility, dressing, toileting, personal hygiene, and was dependent upon staff for transfers. Bathing was documented as Did not occur entire period, on the 7/14/2020 MDS assessment.<br><br>Review of Resident #27's ADL Care Plan, printed 9/11/2020, revealed the following, in part:<br><br>Nail Care - Trim [Resident #27's] nails on shower days and as needed, Revision on 7/13/2020.<br><br>ADL - Personal Hygiene assist as needed, Revision on: 07/08/2020.<br><br>ADL - Bathing (Prefers: SHOWER, WEDNESDAY AND SATURDAY DAY SHIFT, Revision on: 07/22/2020.<br><br>ADL - Dressing assist as needed, Revision on: 07/08/2020.<br><br>During an interview on 9/10/20 at 8:35 a.m., Resident #27 was observed lying in bed, wearing a hospital gown. Resident #27 said that he did not get dressed into other clothing but remained in the hospital gown all day. When asked when the last shower was received, Resident #27 stated, Before I got here. Resident #27 stated, If I ring the call light they will show up, but they are kind of shorthanded . This is my life 24/7 . it is solitary confinement. Resident #27 said that he did not get out of bed into a wheelchair, and no wheelchair was observed in the room.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #27's Point of Care (POC) Response History for the last 30 days (8/15/20 - 9/9/20) revealed Resident #27 was either totally dependent, or required physical help in part of bathing activity, and refused on three occasions. The POC Response History did not document if the Bathing was a full-body bath/shower or sponge bath.<br><br>During an observation on 9/10/20 at approximately 8:38 a.m., LPN J and LPN N [working as a Certified Nurse Aide (CNA)] were asked to assist in observation of Resident #27's toenails, fingernails, and coccyx skin integrity. Resident #27's toenails were long and thickened, and fingernails were long and contained brown residue underneath the nails. When asked if their fingernails were long, Resident #27 stated, I would say so! When asked when they were last trimmed, Resident #27 stated, It has been awhile. LPN N, working as a CNA, stated, He needs a podiatrist. Resident #27 said he was able to use his shaver but was unable to trim his nails because he was losing the ability to use his hands. Resident #27 stated, I never get dressed. Observation of Resident #27's coccyx found a small, circular wound, measured by LPN N, working as a CNA, as 0.3 centimeters (cm) in diameter. Resident #27 stated, They don't get me up at all . I have refused on occasion to get up, but now I think they have termed it that I don't want to get up at all .It is not that I don't want to get up and that I don't want to move .<br><br>During interviews on 9/11/2020 at 8:45 a.m. and 9:18 a.m., Staff I was asked about residents not being dressed, other than in a hospital gown. Staff I indicated understanding of this Surveyors concern, and stated, I have had several discussions with Administration about staffing (short-staffed and new staff) and the lack of grooming - haircuts, nails . When asked about documentation for staff completion of fingernail and toenail trimming, Staff I stated, Nails are PRN (as needed) and don't come up on tasks (for completion on the computer). Staff I said that documentation of nail care being performed would not be present on the CNA tasks.<br><br>Review of the Activities of Daily Living (ADLs) policy, Copyright 2020, revealed the following, in part: .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .<br><br>35102<br><br>Resident #47<br><br>According to Resident #47's MDS assessment, dated 8/5/20, showed an admitted [DATE] with Alzheimer's disease and dementia diagnoses. Resident #47 had no speech-absence of spoken words and was rarely/never understood/understands. The same assessment showed one staff assistance was needed for dressing, eating, and personal hygiene. Resident #47 had functional limitation in range of motion to both upper extremities.<br><br>On 9/3/20 at 10:00 a.m., when Resident #47's sheet was drawn back, her pants were found pushed down around her ankles in the presence of Licensed Practical Nurse (LPN) Z during a skin assessment observation.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 9/4/20 at 1:20 p.m., Resident #47's lunch tray was found on a bedside table in her room. No staff were in the room. A clothing protector remained over Resident #47's chest. Items on the lunch tray had not been prepared for consumption (water lid unpunctured for a straw), pudding unopened, pureed food (three sections) smooth without evidence of a utensil being used. A clean, clear, plastic spoon remained on a napkin to the right side of the plate.<br><br>Review of Resident #47's Food Acceptance Record for 9/4/20 showed 76%-100% of the lunch was eaten.<br><br>During an interview on 9/9/20 at 2:20 p.m., CNA II confirmed documenting Resident #47's food acceptance for 9/4/20's lunch tray at 1:00 p.m. although the uneaten tray was observed the same day at 1:20 p.m. The Interim DON and CNA II said sometimes other staff provide the food consumption information that gets entered by another staff person.<br><br>During an observation on 9/10/20 at 11:50 a.m., Resident #47's fingernails and toenails were observed in the presence of LPN GG and CNA HH and were found to extend past the tips of the fingers/toes (approximately 1/4 to 1/2 centimeters). Resident #47's had closed fists due to contractures to both hands and overlapping toes bilaterally. When asked if the nails were in need of trimming, CNA HH said, Yeah, they look like they could be cut.<br><br>Resident #32<br><br>According to the MDS Significant Change assessment, 7/22/2020, Resident #32 was admitted to the facility on [DATE] with the following major diagnoses: Alzheimer's disease, dementia, and depression. The same assessment indicated Resident #32 had no speech (absence of spoken words), was rarely/never understood nor understands, and had severely impaired cognition. Resident #32 was dependent on staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.<br><br>All repeated observations of Resident #32 (until 4:00 p.m. each day) on 9/2/20, 9/3/20, and 9/4/20 showed he remained in his bed with an unshaven face.<br><br>Review of Resident #32's CNA documentation until 9/10/20 for a 14-day lookback period revealed shaving was provided only on 8/20/20 and 9/8/20.<br><br>Review of Resident #32's ADL Care Plan, revision 4/17/20, read in part, .unable to make his needs known to staff .dependent on staff for all ADL's.<br><br>During an interview on 9/10/20 at 2:15 p.m., when asked why Resident #32 had not been out of bed with having a Stage III pressure ulcer, LPN Z said staffing (shortages) was the reason and added that for continuity of care that the care plans needed to be followed. |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103<br><br>Based on observation, interview, and record review, the facility failed to provide care and services to prevent the development of pressure ulcers, and failed to provide treatment and services consistent with professional standards of practice to prevent infection, promote healing, and prevent the development of additional pressure injuries for five Residents (#4, #27, #32, #41, and #46) of eight residents reviewed for pressure ulcers. This deficient practice resulted in harm when Residents developed new, facility acquired Stage II, Stage III, and Stage IV pressure injuries, deterioration of wounds, and the potential for wound infections. Findings include:<br><br>Resident #4<br><br>Review of Resident #4's Minimum Data Set (MDS) assessments, dated 2/26/20 and 5/28/20 revealed Resident #4 was admitted to the facility with diagnoses that included: heart failure, renal failure, urinary retention, diabetes mellitus, and mild cognitive impairment. Resident #4 scored 12 of 15 on the Brief Interview for Mental Status (BIMS) reflective of moderate cognitive impairment on the initial MDS assessment and 14/15 on the 5/28/20 assessment, reflective of intact cognition. Resident #4 required extensive, two-person assistance with bed mobility, transfers, and toileting on both assessments. Review of Section M - Skin Conditions, revealed Resident #4 was at risk for pressure ulcer development, and had one unstageable pressure ulcer, covered by slough or eschar upon admission. No Deep Tissue Injuries (DTIs) were noted on the 2/26/20 MDS assessment. Interventions listed on the 2/26/20 MDS assessment included pressure reducing chair, pressure reducing bed, nutrition, and pressure ulcer care. Turning and Repositioning was not checked as an intervention on the 2/26/20 MDS assessment. Section M - Skin Conditions on the 5/28/20 quarterly MDS assessment revealed one Stage III (three) and one Stage IV (four) pressure ulcer that were not present upon entry.<br><br>During an observation of wound care for Resident #4 on 9/3/2020 at 2:23 p.m., Licensed Practical Nurse (LPN) Q removed the soiled dressing from Resident #4's right buttock, and showed this Surveyor the soiled dressing removed from the interior of the wound, approximately 1/2 to 3/4 inch in length, and pencil-like shape/width in diameter, with yellowish/tan exudate that was thrown into the garbage. LPN Q stated, This wound was acquired in the facility. He did not come to the facility with the wound. LPN Q removed her gloves, sanitized her hands, and donned new clean gloves. LPN Q cleansed Resident #4's right buttock Stage IV pressure ulcer, and patted it dry with gauze 4x4s. Using the same gloves LPN Q used her gloved finger to press/pack the kerlix gauze into the Stage IV right buttock wound. LPN Q did not use a sterile cotton-tipped applicator, to insert into the wound while packing the gauze into the wound bed.<br><br>Review of the facility Wound Care policy, Revised October 2010, revealed the following, in part: .Use a no-touch technique. Use sterile tongue blades and applicators .Wear sterile gloves when physically touching the wound or holding a moist surface over the wound .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 9/9/2020 at 8:30 a.m., Licensed Practical Nurse (LPN)/Wound Care Nurse Z said Resident #4's wounds started on 3/5/2020 and were labeled as acquired in house. LPN Z stated, It (pressure ulcers) began with a DTI - deep tissue injury to the right buttock, which moved up to the coccyx a few days later then on to the left buttock a few days after that. It was a new pressure injury as of 3/5/2020. The coccyx was a fluid filled blister. LPN Z said Resident #4's pressure injury to the right buttock was currently a Stage IV wound. Review of the Weekly Pressure Ulcer Status Report logs, from 3/1/2020 through 9/5/2020 with LPN Z confirmed the following development of facility acquired pressure ulcers for Resident #4:<br><br>3/5/2020 New Right Buttock DTI measured 7.0 x 7.5 cm (centimeters).<br><br>3/7/2020 New Left Buttock DTI measured 8.5 x 6.0 cm.<br><br>3/7/2020 New Coccyx Stage II (two) pressure injury measured 2.0 x 2.0.<br><br>When asked about the date of wound documentation on the Weekly Pressure Ulcer Status Report log, LPN Z confirmed the weekly logs listed a weekly period and did not identify the exact date of wound assessments, including measurements, drainage, and deterioration or improvement. When asked if some resident wounds could be measured three days apart, and some 10 days apart, LPN Z stated, I see your point. When asked about how she would dress Resident #4's Stage IV wound after cleansing with soap and water, LPN/Wound Care Nurse Z stated, I would use a sterile cotton-tipped applicator . I would do it with a cotton-tipped applicator because that is how you do it. The cotton-tipped applicator is clean, your (gloved) finger is not clean .<br><br>Review of Resident #4's Care Plan revealed the following: [Resident #4] has a pressure injury to his right buttock. Date Initiated: 04/14/2020, Revision on 04/30/2020 . Administer [Resident #4's] treatment to right buttock pressure injury per MD orders. Cleanse with soap and h20 (water), rinse, pat dry. Lightly pack wound with AMD Kerlix and cover with Silicone border Foam 4 x 4. Change daily and as needed. Date initiated: 4/14/2020, Revision on: 05/29/2020.<br><br>Review of Resident #4's Progress Notes revealed Resident #4 had the following notes documented:<br><br>3/2/2020 15:02 (3:02 p.m.) Resident right buttock unstageable pressure injury is resolved. Treatment order d/c'd .<br><br>3/3/2020 00:55 (12:55 a.m.) right buttock wound with dressing C/D/I (clean, dry, intact).<br><br>3/3/2020 02:22 (2:22 a.m.) resident reports bilateral leg pain at '9' and he is not able to sleep due to the pain .<br><br>3/4/2020 22:25 (10:25 p.m.) Res (resident) resting in bed, required assist of 1 or 2 with bed mobility r/t (related to) immobile legs .<br><br>3/5/2020 01:52 (1:52 a.m.) Resident reports he is not able to move his legs and left arm due to extreme pain .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 3/5/2020 11:30 (11:30 a.m.) .nurse went to reposition resident and check buttocks, purple are noted to right buttocks, nurse and tx (treatment) nurse assessed site, area measure 7.0 x 7.5 cm, purple and non-blanchable near coccyx. Will turn and reposition frequently . Resident has not been moving himself in bed as he was before, able to move legs a little when asked .<br><br>3/5/2020 15:58 (3:58 p.m.) The Change in Condition/s reported on this CIC Evaluation are/were: Skin wound or ulcer .not turning in bed as he was before, zinc applied and will reposition often .<br><br>3/7/2020 11:28 (11:28 a.m.) .Resident states pain level of 10 .right and left buttocks purple in color, also coccyx, skin is wrinkled right buttocks area but intact .<br><br>3/7/2020 15:00 (3:00 p.m.) The Change in Condition/s reported on this CIC Evaluation are/were: Skin wound or ulcer . Nursing observations, evaluation, and recommendations are; resident with non-blanchable purple areas to right and left buttocks, 5 intact blisters to right buttocks and near coccyx, one popped blister right buttocks . needs more assistance with ADLs General weakness decreased mobility .<br><br>3/7/2020 16:54 (4:54 p.m.) New non-blanchable purple area noted to left buttocks this morning when nurse and staff was turning resident and doing cares. 5 intact blisters noted to right buttocks and coccyx area and one popped blister to right buttocks noted this afternoon . Resident denies pain to buttocks, states pain level of 9 to hand and knee joints bilateral .<br><br>3/9/2020 15:02 (3:02 p.m.) Resident with new DTI to left buttock .Wound measure 8.5 x 6.0 x 0.0 cm. Right buttock DTI with decline . Area measure from right buttock into coccyx 10.5 x 8.6 x <0.1 cm. Intact blister in coccyx measures 2.0 x 2.0 cm . Resident is now on LAL (low air loss) mattress and is on a turning schedule r/t recent decline in mobility .<br><br>4/9/2020 15:15 (3:15 p.m.) Right buttock unstageable pressure (injury) . Periwound . Stage 3 pressure injury . Coccyx crease unstageable pressure injury now classified as stage 3 pressure injury .<br><br>4/20/2020 13:48 (1:48 p.m.) .Right buttock unstageable pressure injury, now classified as stage 4 pressure injury . Stage 3 pressure injury to right buttock is resolved .Coccyx crease Stage 3 pressure injury .<br><br>5/29/20 14:41 (2:41 p.m.) .Residents depends, pants, lift pad, two blue pads under resident and wheelchair cushion were saturated with blood. Dressing to right buttock (Stage 4 Pressure Injury) saturated with steady flow of large amount of blood coming from wound. Dressing removed and packing gently removed. Pressure held to wound for > (greater than) 10 minutes .<br><br>9/4/2020 17:04 (5:04 p.m.) Wound care completed to residents right buttock stage 4 pressure injury .<br><br>During an interview on 9/10/2020 at 2:06 p.m., LPN Z again confirmed Resident #4's Stage IV right buttock pressure ulcer should be packed with sterile gauze using a cotton-tipped applicator. When asked other nursing staff had been assessed for competency on wound care, LPN/Wound Care Nurse Z stated, I have not done any competencies on wound care of the staff.<br><br>Resident #27:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #27's Minimum Data Set (MDS) assessment, dated 7/14/2020, revealed Resident #27 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (MS) and depression. Resident #27 scored 14 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition, however Resident #27's spouse served as both medical and financial guardian for the Resident. Resident #27 required extensive, two-person assistance with bed mobility, dressing, toileting, and personal hygiene, and was dependent upon staff for transfers. Review of Section M - Skin Conditions, revealed Resident #27 was at risk for pressure ulcer development, but had no unhealed pressure ulcers at the time of the assessment.<br><br>During an interview on 9/10/20 at 8:35 a.m., Resident #27 was observed lying in bed, wearing a hospital gown. Resident #27 said that he remained in bed during the day and did not get up into a wheelchair at all during the day. No wheelchair was observed in Resident #27's room.<br><br>During an observation on 9/10/20 at approximately 8:38 a.m., LPN J and LPN N [working as a Certified Nurse Aide (CNA)] were asked to assist in observation of Resident #27's coccyx skin integrity. Observation of Resident #27's coccyx found a previously unidentified small, circular wound, measured by LPN N, working as a CNA, as 0.3 cm in diameter. Resident #27 stated, They don't get me up at all . I have refused on occasion to get up, but now I think they have termed it that I don't want to get up at all .<br><br>Review of Resident #27's Progress Notes, Care Plans, and Physician Orders, found no documentation of the coccyx wound, which appeared to be a Stage II pressure injury, prior to the date of this Surveyor's observation of the wound on 9/10/20 at 8:38 a.m.<br><br>Review of Resident #27's Progress Notes revealed the following:<br><br>9/10/20 14:42 (2:42 p.m.) .The Change in condition/s reported on this CIC Evaluation are/were: Skin wound or ulcer . Nursing observations, evaluation, and recommendations are: Residents coccyx observed due to Nursing reports of open area. New stage 2 pressure injury noted to coccyx. Wound measures 0.3 x 0.4 x <0. 1 cm Wound bed with non-granular pink tissue, wound edges attached . Primary Care Provider responded with the following feedback: A. Recommendations: Wound Care: Coccyx Pressure Injury - Cleanse wound with soap and h20 (water), rinse, pat dry. Apply skin prep (Barrier Film) to periwound and allow to dry. Cover wound with 3x3 silicone bordered foam dressing. Change daily and as needed. Continue with turning and repositioning .<br><br>Review of Resident #27's Care Plans revealed, [Resident #27] has a pressure injury to his coccyx, Date Initiated: 9/10/2020 .<br><br>Review of the Weekly Pressure Ulcer Status Report did not include Resident #27 on the last log received from the facility dated 8/30/20 - 9/5/20.<br><br>During an interview on 9/10/20 at 11:40 a.m., when asked about knowledge of Resident #27's coccyx wound, LPN/Wound Care Nurse Z stated, (It) was reported (to LPN Z) that Resident #27 did have a small open area to the coccyx. It is most likely a Stage II (pressure injury) . I am not aware that he [Resident #27] gets out of bed . from what I understand.<br><br>Resident #46:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #46's MDS assessment, dated 5/5/2020, revealed Resident #46 was admitted to the facility with a Stage IV pressure ulcer at the time of admission.<br><br>Resident #46 required extensive, two-person assistance with bed mobility, transfers, dressing, and toileting. Resident #46 scored 9 of 15 on the BIMS, reflective of moderate cognitive impairment.<br><br>Review of the facility Weekly Pressure Ulcer Status Report, dated 4/26/20 through 9/5/20, with a log sheet for each week that listed each resident with a pressure ulcer, found Resident #46 on the pressure ulcer log, and the logs included the following, in part:<br><br>4/28/20 admitted Stage IV Coccyx Pressure Ulcer (PU), 4.5x1.2x1.5 cm, New.<br><br>5/31/20 - 6/6/20: Stage IV Coccyx PU, 3.1 x 0.8 x 1.0 cm.<br><br>7/5/20 - 7/11/20: Stage IV Coccyx PU, 2.4 x 0.4, 0.4 cm.<br><br>7/12/20 - 7/18/20: Stage IV Coccyx PU, 2.0 x 0.4 x 0.3 cm.<br><br>7/19/20 - 7/25/20: [NAME] IV Coccyx PU, 2.1 x 0.5 x 0.3 cm, stable. (Increased in size)<br><br>7/26/20 - 8/1/20: Stage IV Coccyx PU, 2.0 x 0.4, x 0.4 cm, stable.<br><br>8/9/20 - 8/15/20: Stage IV Coccyx PU, 1.9 x 0.5 x 0.4 cm, improvement. (remained stable)<br><br>8/30/20 - 9/5/20: Stage IV Coccyx PU, 2.4 x 0.4 and 0.3 cm, stable (increased in size)<br><br>Review of Skin/Wound Notes correlating to the documentation on the Weekly Pressure Ulcer Status Report revealed the following discrepancies:<br><br>6/4/20 11:52 p.m. Wound measures 3.0 x 0.5 x 1.0 cm, Fistula at 6 o'clock measure 0.3 and 0.3 cm, unable to measure depth of fistula . does not reflect measurement documented 5/31/2- - 6/6/20 on the Weekly Pressure Ulcer Status Report.<br><br>7/10/20 11:40 a.m., Skin/Wound Note . Wound measures 2.0 x 0.4 x 0.3 cm . Fistula at 6 o'clock measures 0. 2 x.0.1 cm, fistula depth unable to be measured . does not reflect measurement documented on 7/5/20 - 7/11/20 Weekly Pressure Ulcer Status Report.<br><br>No documentation in Skin/Wound Note was found for any pressure ulcer measurement for Resident #46 the week of 7/12/20 - 7/18/20, although measurements were documented on the weekly PU log.<br><br>No documentation in Skin/Wound Note was found for any pressure ulcer measurement for Resident #46 the week of 7/19/20 -7/25/20, although measurements were documented on the weekly PU log.<br><br>No documentation in Skin/Wound Note was found for any pressure ulcer measurement for Resident #46 the week of 7/26/20 - 8/1/20, although measurements were documented on the weekly PU log.<br><br>8/4/20 13:05 (1:05 p.m.), New order from [Physician] for Bactrim DS one p.o. BID for positive wound culture to sacrum .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 8/9/20 - 8/15/20, No Skin/Wound note measurements found in progress notes, but wound measurements documented in weekly PU log. Unable to determine source of the measurements.<br><br>8/30/20 - 9/5/20, Stage IV Coccyx wound measurements of 2.4 x 0.4 x 0.3 cm deteriorated to a comparable measurement as the week of July 5 2020 - 7/12/2020 of 2.4 x 0.4 x 0.4 cm.<br><br>8/25/20 12:40 p.m. Resident's Stage IV Coccyx pressure ulcer was measure, followed by a measurement on 9/4/2020, 10 days apart. The wound increased from 1.8 x 0.4 x 0.3 to 2.4 x 0.4 x 0.3 during that 10-day period.<br><br>During an interview on 9/10/20 at 1:40 p.m., LPN/Wound Care Nurse Z was asked to review the Weekly Pressure Ulcer Status Report logs, specific to Resident #46. LPN Z confirmed she had received her Wound Care Certification and was aware of proper infection control practices during wound care. When asked about completion of wound measurements/assessment during LPN Z's absence from the building, LPN Z stated, If I am on vacation, they (nursing staff) do not do the measurements. When asked about the increased measurement of Resident #46's Coccyx Stage IV pressure ulcer between 8/30/20 and 9/5/20, LPN Z stated, I think I measured it standing up one time and laying on his side one time. When asked about the wound documented as stable, even though the wound had increased to 2.4 x 0.4 x 0.3 cm, from the previous weeks 1.8 x 0.4 x0.3 cm, LPN Z stated, With increased size, I get what you are saying. When asked about the discrepancies between progress note documentation and the Weekly Pressure Ulcer Status Report, LPN Z stated, My charting is not there - I can't argue with that . 6/4/2020 that may have been just an error on that one. I don't know why the heck that one is in there (from 6/4/2020). I need to correlate my charting and do a weekly note. LPN Z did confirm there were no specific days that wounds were measured/assessed, and the time frame could vary significantly depending if wounds were measured on the first day of one week and the last day of the next week.<br><br>Review of the facility Wound Care policy, Revised October 2010, revealed the following, in part: Documentation: The following information should be recorded in the resident's medical record:<br><br>1. The type of wound care given<br><br>2. The date and time the wound care was given.<br><br>3. The position in which the resident was placed.<br><br>4. The name and title of the individual performing the wound care.<br><br>5. Any change in the resident's condition.<br><br>6. All assessment data (i.e., wound bed color, size, drainage, etc._ obtained when inspecting the wound.<br><br>7. How the resident tolerated the procedure.<br><br>8. Any problems or complaints made by the resident related to the procedure.<br><br>9. If the resident refused the treatment and the reason(s) why.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 10. The signature and title of the person recording the data.<br><br>35102<br><br>Resident #41<br><br>According to MDS assessment, dated 8/5/20, Resident #41 was admitted to the facility on [DATE] with the following diagnoses: heart failure, pneumonia, respiratory failure, sepsis, urinary tract infection, renal failure with dialysis, diabetes, anemia, and hypertension. Resident #41 required two-person staff assistance for bed mobility, transfers, and toilet use. The BIMS score was 15 out of 15 which indicated intact cognition.<br><br>During an interview and observation on 9/3/20 at 10:05 a.m.,Wound Care/Licensed Practical Nurse (LPN) Z said Resident #41's Stage III pressure ulcer was healed and no dressing was in place. Resident #41 then said there was a dressing which was placed by Transporter (Staff) EE. LPN Z removed the large dressing which revealed a penny sized area covered with a partial scab over scar tissue on the coccyx. The dressing was not reapplied.<br><br>During an interview on 9/3/20 at 3:07 p.m., LPN Z said the dressing found on Resident #41's coccyx was not ordered and believed moisture caused the scarring to reopen the skin. LPN Z confirmed it was not within the scope of a transporter to perform wound care when the dressing was placed on Resident #41.<br><br>During an interview on 9/4/20 at 1:40 p.m., the Director of Nursing (DON) confirmed it was not appropriate for Staff EE to perform wound care on Resident #41.<br><br>Resident #32<br><br>According to the MDS Significant Change assessment, 7/22/2020, Resident #32 was admitted to the facility on [DATE] with the following major diagnoses: Alzheimer's disease, dementia, and depression. The same assessment indicated Resident #32 had no speech (absence of spoken words), was rarely/never understood nor understands, and had severely impaired cognition. Resident #32 was dependent on staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. The same assessment indicated one Stage III pressure ulcer (full thickness tissue loss) was not present upon admission/reentry.<br><br>On 9/3/20 at 10:40 a.m., LPN Z performed wound care on Resident #32's coccyx wound. Wound measurements were not taken but estimated to be larger than the size of a quarter. The wound was classified as a Stage III wound. Resident #32 withdrew and moaned several times when the wound was touched during the dressing change.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 9/10/20 at 10:06 a.m., LPN Z confirmed Resident #32's skin breakdown to the coccyx first occurred on 3/29/20 per Progress Note review. On 4/16/20 wound measurements were 2.1 cm x 0.8 cm x < 0.1 cm and the wound was classified as Unstageable. Resident #32's 5/7/20 Progress Note showed the coccyx wound was first classified as a Stage III pressure ulcer. LPN Z reviewed wound management for June, July, and August 2020. On 8/7/20, the Stage III wound measured 1.0 cm x 0.4 cm x < 0.2 cm. A Progress Note on 8/15/20 reported the wound was left open to air (without a dressing). A second Progress Note on 8/16/20 indicated a (brand name) dressing was applied. When asked, LPN Z confirmed wound care orders were not followed according to the Progress Notes on 8/15 and 8/16 in her absence. Resident #32's 8/20/20 Progress Notes indicated the coccyx wound size had increased/worsened to 2.5 cm x 2.4 cm x <0.3 cm and was classified as a Stage III wound.<br><br>Review of facility's, eINTERACT Change of Condition Evaluation V5 dated 8/20/20 read, .Resident (#32) has a stage 3 pressure injury with treatment in place. Wound with significant decline . |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>35103<br><br>Based on observation, interview, and record review, the facility failed to provide restorative services to maintain or improve range of motion for 10 Residents (#3, #4, #17, #18, #21, #27, #28, #46, and #54) of 12 residents reviewed for restorative services/activities of daily living (ADLs). This deficient practice resulted in potential decrease in range of motion, and potential decrease in independence in activities of daily living. Findings include:<br><br>During interviews on 9/2/20 at 2:55 p.m. and 9/3/20 at 2:45 p.m., when asked about the Restorative Program conducted at the facility, Restorative Aide (RA)/Certified Nurse Aide (CNA) S stated, I am supposed to do restorative five days a week, but I am lucky if I get to do it one time a week .I keep track of them (the days I get pulled off of restorative) on my calendar at home waiting for the day you guys (State Agency Surveyors) show up because it is frustrating and I cannot do my job .I am the only restorative (aide). When I am on vacation (or off) it does not get done . They (scheduler/administration) pull me to the floor to provide general cares all of the time .<br><br>Review of a handwritten list of days Pulled from Restorative, received from CNA S on 9/3/20 at 8:33 a.m., revealed the following days reported as being pulled from restorative to the floor for partial or full days: 7/21, 7/23, 7/27, 7/28, 7/29, 8/3, 8/5, 8/6, 8/7, 8/10, 8/17, 8/20, 8/24, 8/25, 9/1, 9/2, and 9/3.<br><br>During an interview on 9/3/2020 at 1:27 p.m., Licensed Practical Nurse (LPN)/Scheduler M reviewed the daily staffing sheets and confirmed CNA was pulled from performing restorative services to work as a regular CNA due to problems with staff the floor for resident care. LPN M stated, Problem shifts (for sufficient staffing) right now seem to be almost all of them. We have had shifts we can barely cover (with enough staff). LPN M identified July 28th, August 3rd, 6th, 7th, 10th, 24th, September 1st, 2nd, and 3rd as days CNA S was pulled from restorative services to work the floor as a CNA.<br><br>During an interview on 9/3/2020 at 1:10 p.m., when asked if Restorative (range of motion active and/or passive exercises) services were provided as scheduled, Resident #28 stated, Absolutely not! I don't get it often enough because they don't have enough staff to do it.<br><br>Review of Residents (#3, #4, #17, #18, #21, #27, #28, #46, #54, and #62) Therapy Communication to Restorative Nursing Program listed each resident's Current Functional Status, Problem/Needs, and Recommendations/Approaches (for passive and/or active range of motion exercises to be completed by the restorative aide with each resident). No Therapy Communication to Restorative Nursing Program sheet was found for Resident #62, but documentation of restorative services was present in the Documentation Survey Report for June, July, and August 2020.<br><br>Review of Residents (#3, #4, #17, #18, #21, #27, #28, #46, #54, and #62) Documentation Survey Report related to documentation of restorative care/range of motion exercises by CNA S revealed the following weeks from June 2020 through September 7th, 2020 where restorative services recommended by Physical Therapy were not met, in part:<br><br>Resident #62 (2-5 times per week) - 6/20 - 6/30 completed once, and 7/5 - 7/14 completed once.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #46 (2-5 times per week), 9/1 - 9/7 completed once.<br><br>Resident #17 (3-5 days per week), 9/1 - 9/7, completed once.<br><br>Resident #4, (2-5 times per week), 9/1 - 9/7, completed once.<br><br>Resident #28, (2-5 times per week), 6/27 - 7/7, absent documentation, 8/1 - 8/9, completed once.<br><br>Resident #18, (2-3 times per week), 6/27 - 7/6, absent documentation, 8/8 - 8/17 completed once.<br><br>Resident #54, (2-3 times per week), 9/1 - 9/7, completed once, 6/27 - 7/6, completed once.<br><br>Resident #21, ((3-5 times per week), 6/27 - 7/6, absent restorative documentation, 9/1 - 9/7, completed once.<br><br>Resident #3, (2-5 times per week), 6/27 - 7/7, absent restorative documentation, 8/5 - 8/19, completed once.<br><br>Resident #27, (2-5 times per week), 822 - 8/31, completed once 9/1 - 9/7, completed once.<br><br>Review of RESTORATIVE NURSING AT-A-GLANCE, Restorative Nursing Programming ., Revised 9/12, received from Business Office Manager on 9/3/2020 at 10:50 a.m., revealed the following, in part: Administrative Staff . Ensure back-up for Restorative Aides . Do not pull Restorative Aides to floor for general care.<br><br>Review of the facility Restoratie Nursing Services policy, revised July 2017 revealed the following, in part: Residents will receive restorative nursing care as needed to promote optimal safety and independent .<br><br>During an interview on 9/4/2020 at approximately 2:54 p.m., when asked about the Restorative aide being pulled to the floor for general cares, the Director of Nursing (DON) acknowledge the Restorative aide was pulled to the floor, and did not provide restorative care services when scheduled as a regular CNA. The DON stated, We are not supposed to pull Restorative Aides to the floor for general care. We have had staffing difficulties. We have continued to take admissions. I complete or 100% agree that we should have stopped admissions until we could get our staff under control. Pretty much we have nurses on the floor as CNA's every day . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35102<br><br>Intake: MI00111062<br><br>Based on observation, interview, and record review, the facility failed to ensure two Residents (#47 and #41) were transferred safely while using a mechanical lift/gait belt out of five residents reviewed for falls. This deficient practice resulted in Resident #47's minor injury and had the potential for more serious injuries. Findings include:<br><br>Resident #47<br><br>According to the Facility Reported Incident, 2/29/20, Read, (Resident #47) was found to have a small lump and abrasion to her forehead .CNA (Certified Nurse Aide) who worked on afternoon (also worked day shift), did transfer (Resident #47) by herself . Policy states that anyone who is a full body mechanical lift, requires 2 person assist .<br><br>According to Resident #47's Minimum Data Set (MDS) assessment, dated 8/5/20, showed an admitted [DATE] with Alzheimer's disease and dementia diagnoses. Resident #47 had no speech-absence of spoken words and was rarely/never understood/understands. The same assessment showed two staff person assistance was needed for bed mobility, transfers, and toilet use. Resident #47 had functional limitation in range of motion to both upper extremities.<br><br>During a telephone interview on 7/11/20 at 6:45 a.m., CNA FF acknowledged transferring Resident #47 using a mechanical full body lift by herself just prior to the dinner meal.<br><br>During an interview on 09/10/at 12:26 p.m., Interim Director of Nursing (DON) said CNA FF did not follow Resident #47's Care Plan which required a two person assist for the transfer.<br><br>Resident #41<br><br>On 9/3/20 at 10:05 a.m., Licensed Practical Nurse (LPN) Z asked Resident #41 to stand up from bed without the use of a gait belt for a skin inspection to her coccyx. A walker was placed in front of Resident #41. Resident #41 rocked back and forth several times (to gain momentum) just prior to lifting her body off the bed.<br><br>According to MDS assessment, dated 8/5/20, Resident #41 was admitted to the facility on [DATE] with the following diagnoses: heart failure, pneumonia, respiratory failure, sepsis, urinary tract infection, renal failure with dialysis, diabetes, anemia, and hypertension. Resident #41 required two-person staff assistance for bed mobility, transfers, and toilet use. The BIMS score was 15 out of 15 which indicated intact cognition. The same assessment indicated a fall history prior to admission.<br><br>Review of facility provided Risk Management notes, 8/3/20 and 8/6/20, showed Resident #41 had two recent falls in her room.<br><br>(continued on next page) |

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| Mission Point Nsg & Phy Rehab Ctr of Ishpeming | 435 Stoneville Rd<br>Ishpeming, MI 49849 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #41's Activity of Daily Living (ADL) Care Plan intervention, revision 8/28/20, read in part, OK to ambulate (Resident #41) with 1 assist and gait belt .<br><br>During an interview on 9/03/20 at 3:02 p.m., Restorative Aide/CNA S confirmed Resident #41 required a gait belt with transfers.<br><br>During the same interview on 09/10/20 at 12:26 p.m., Interim DON confirmed Resident #41 required the use of a gait belt for transfers and said CNA Tasks (within the electronic medical record) specifically would address if the gait belt was needed.<br><br>Review of Resident #41's CNA Task: ADL (Activity of Daily Living) read in part, One person assist with gait belt. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383<br><br>Based on observation, interview, and record review, the facility failed to assess, monitor and maintain nutritional status of one Resident (# 16) of 5 residents reviewed for nutritional needs. This deficient practice resulted in unwanted weight gain and potential for continued weight gain and compromised health conditions. Findings include:<br><br>Review of the medical record for Resident #16 revealed an admitted [DATE] and diagnoses of multiple CVAs (Cardiovascular Accidents or strokes), cardiac arrest, major depressive disorder, anxiety disorder, gastrointestinal hemorrhage, gastro-esophageal reflux disease (GERD), Diabetes Mellitus (Type 1), and post-traumatic stress disorder. The physician orders included a diet order dated: 8/12/20 of carbohydrate controlled, mechanical soft texture, regular consistency diet. The Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #16 was cognitively intact.<br><br>On 9/10/20, at approximately 9:45AM, Resident #16 stated that she requested salads and food she would like from the kitchen. A bowl of salt and pepper packets was observed on the bedside table along with a dietary tray card that revealed a diet of CC (Carbohydrate Controlled), NAS (No Added Salt), Mechanical Soft diet. (The current diet order did not include a salt restriction and did not match the tray card.) Resident #16 remarked that the trays often did not have salt and pepper and the food needed more seasoning. Resident #16 stated that yesterday she had ordered a pizza from a local restaurant to go with her salad. She discussed her weight and noted she had been gaining weight. Resident #16 stated, I absolutely do not want to continue to gain weight. I would like to talk to the dietitian . I have not talked to her.<br><br>The nutritional documentation was reviewed in the medical record and revealed the last nutritional note in the chart had been written by the Registered Dietitian (RD) B on 2/15/2020 and read in part: Triggered for 10% gain in past 6 months . Nutrition diagnosis: Involuntary weight gain R/t (with regards to) excessive energy intake AEB (as evidenced by) Rst (Resident) gained 17.4# in the past 6 months. Recommendation: Rst to be weighed weekly x 4 weeks per admission protocol. RD to continue to follow labs, weight, fluid intake and food acceptance. Goal: Rst to no longer trigger for a significant weight gain on/before 3/15/2020. No further RD notes or nutritional assessments were found in the medical record. The last nutritional assessment was dated 12/18/19. The section of the medical record with quarterly dietary assessments did not have a quarterly assessment since 9/11/2019. The weights of Resident #16, taken after the RD note of 2/15/20 above, indicated a 10% weight gain:<br><br>3/2020 = 177.4#<br><br>4/2020 = 180#<br><br>5/2020 = 179.6#<br><br>6/2020 = 177#<br><br>7/2020 = 178.2#<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 8/2020 = 184.2#<br><br>9/2020 = 195.4#<br><br>On 09/09/20 at 01:34 PM, the Dietary Manager (DM) A stated that she does the nutrition assessments. DM A stated, I have not done all of them . I came June 6th (2020) and have just started taking the dietary manager class. The dietary manager class syllabus was reviewed, and it was observed that there were 3 units with 5 lessons each (Unit 1 was on food preparation and storage. Unit 2 was on food service management. Unit 3 was on nutrition and medical nutrition therapy.) DM A had finished one lesson from the first unit - When asked about nutritional assessments DM A replied I have not done that part of the class yet. She was unsure of BMI (Body Mass Index) or carbohydrate controlled diets. DM A had minimal contact with RD B and stated, I think she works remotely; I have not seen her since I started.<br><br>On 09/9/20 at 3:19 PM, Licensed Practical Nurse (LPN) Z was interviewed regarding assessments for the Minimum Data Set. LPN Z stated, Yes, some nutritional assessments are missing . All of the sudden the quarterly assessments stopped getting done. I have an audit . and have asked (RD B) to do the ones that were missed.<br><br>On 9/10/20 at 1:50 PM, RD B stated in a phone conversation, that she was unaware of a weight change, had not reviewed the nutritional status and had not written a note since 2/15/20 for Resident #16. RD B confirmed that she had not been in the facility to meet with Resident #16. RD B stated, The quarterly assessments and the annuals are done by (DM A). She is a CNA (Certified Nurse Aid) . I do precept her for the dietary manager class and she has completed one lesson . I talk to her on the phone . She has only called me one time since she has started. I have offered my assistance, but I have not heard what she would like assistance with.<br><br>The Dietitian Job Description for RD B with a date of hire of 07/12/18 was reviewed. The Duties and Responsibilities section included, .Participate in completing; coding, and revising of the Resident Assessment Instrument (MDS) to ensure the resident's dietary needs are met . Visit residents periodically to evaluate the quality of meals served, likes and dislikes . Review the dietary requirements of each resident admitted to the facility and assist the attending physician in planning for the resident's prescribed diet plan. This document had space for acknowledgement by the RD and the Administrator. Both areas for the RD and for the Administrator were unsigned and undated. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103<br><br>Based on observation, interview, and record review, the facility failed to maintain respiratory equipment in an aseptic manner and according to physician orders and professional standards of practice for two Residents (#9 and #34), of two residents reviewed for oxygen/respiratory care. This deficient practice resulted in the potential for transmission of infectious organisms within improperly maintained and cleaned respiratory equipment, and administration of oxygen not in accordance with physician orders. Findings include:<br><br>Resident #9<br><br>During an interview on 9/2/2020 at 2:32 p.m., Resident #9 reported she had received a recent diagnosis of pneumonia. Resident #9 stated, That (pneumonia) is what I had in the hospital and I don't think it ever went away. During an observation of Resident #9's oxygen concentrator, at this same time, found Concentrator #79, Serial Number #123539, with a card inside of a plastic holder on the concentrator that indicated the date received by the facility was 11/12/18, Date of Service: 11/12/18, with no document of filter change, or preventative maintenance or other repair. The black, foam, exterior filter on the oxygen concentrator was white with debris, and the white lint/debris peeled off in flakes when touched. The black filter appeared to be a white filter due to the large amount of debris within the exterior filter. Observation of Resident #9's nebulizer found the mouthpiece attached to the medication cup, dated 8/31/20. The tubing from the medication cup to the machine was undated. When asked if the nebulizer medication cup and mouthpiece were cleaned by facility staff, Resident #9 stated, No, they have not been cleaning, washing, and letting the nebulizer dry .The . medication cup and mouthpiece sit on the nebulizer machine. Resident #9 stated, About a month ago . about 8:25 p.m., my oxygen concentrator started beeping. At that time, I could get out of bed, so I put my light on, and came back to bed. I waited - a girl came at ten minutes to nine. I told them my concentrator was going on - and nobody came back. I asked her to send for another girl. Nobody ever came back. I turned it back on because nobody came. When if the facility had enough staff to meet resident needs, such as taking care of the oxygen concentrator, Resident #9 stated, Oh my gosh no! They do not have enough staff. [NAME] no! (One) night there was only one Certified Nurse Aide (CNA) and she was covering two halls .<br><br>Observation on 9/4/2020 at 8:25 a.m., found Resident #9's oxygen concentrator set to deliver 3 Liters (L) of oxygen to the resident, and remained white with debris on the back exterior concentrator filter. The nebulizer medication cup and mouthpiece, remained on the nebulizer machine attached, and not taken apart and stored as clean. The medication cup remained dated 8/31/20. No date was present on the nebulizer tubing.<br><br>Review of the Oxygen Administration policy, Revised October 2010, revealed the following, in part: .Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident .:<br><br>Review of Resident #9's Physician Order Summary, dated 9/4/2020, revealed the following:<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. O2 (oxygen) at 2L/Min (Liters per Minute) via nasal cannula continuous every shift. Order Date: 2/21/20, Start Date 2/21/20.<br><br>2. Rinse Oxygen concentrator Filter Weekly and PRN as needed for dirty. Order Date: 3/18/20, Start Date 3/22/20.<br><br>3. Rinse Oxygen concentrator Filter Weekly and PRN every night shift every Sun (Sunday) for per policy. Order Date: 3/18/20, Start Date: 3/22/20.<br><br>4. Ipratropium-Albuterol Solution .1 vial inhale orally every 6 hours as needed for shortness of breath related to Chronic Obstructive Pulmonary Disease with (Acute Exacerbation). Order Date: 2/26/20, Start Date:2/26/20.<br><br>On 9/4/2020 at 8:30 a.m., Licensed Practical Nurse (LPN) M was asked to observed Resident #9's oxygen concentrator and nebulizer with this Surveyor. When asked about the condition of the exterior filter on the oxygen concentrator, LPN M stated, It is dirty - it needs to be cleaned. I will do that. When asked about the storage of the nebulizer medication cup, attached to the mouthpiece on top of the nebulizer machine, LPN M stated, Normally, (nebulizer equipment) is stored on a paper towel. (You) take it apart and put on a paper towel, apart, if it had been cleaned. When asked how this Surveyor would know now that the nebulizer medication cup and mouthpiece had been cleaned, LPN M stated, Not sure. Resident #9 present during the interview said the nebulizer medication cup and mouthpiece had never been cleaned. The respiratory equipment was always repositioned to sit in the holder on the top of the nebulizer machine.<br><br>Review of the facility Administering Medications through a Small Volume (Handheld) Nebulizer, Revised October 2010, revealed the following, in part: When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup . Rinse and disinfect the nebulizer equipment according to facility protocol, or:<br><br>a. Wash pieces with warm, soapy water;<br><br>b. Rinse with hot water;<br><br>c. Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes);<br><br>d. Rinse all pieces with sterile water (NOT tap, bottled, or distilled); and<br><br>e. Allow to air dry on a paper towel .<br><br>When equipment is completely dry, store in a plastic bag with the resident's name and the date on it . Disinfect outside of the compressor between residents, according to manufacturer's instructions .<br><br>9/4/2020 at 8:45 a.m., Maintenance Director X was asked to observe the condition of Resident #9's oxygen concentrator with this Surveyor. Upon visualization of the filter, Maintenance Director X stated, It is filthy - no if, ands, or buts. There is no date on the filter. Maintenance Director X confirmed the Saturation Level on the machine had been checked, but there were no other indications of filter change, or preventive/repair services on the machine since 11/12/18.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/11/2020 at 8:30 a.m., when asked if he could provide any documentation regarding the use, preventive maintenance, filter change, or use by prior residents within the facility, Maintenance Director X stated, I don't have a clue what happened with that machine.<br><br>During an interview on 9/11/2020 at 8:38 a.m., when asked for evidence of preventive maintenance, use by other residents, length of filter use and/or change of filter, Central Supply Clerk Y stated, No, I don't know what happened to that machine (oxygen concentrator). It could have been used. There is no log for that machine .It probably was here 22 months (in the facility) - don't know if anyone else used it. They could have - I don't know.<br><br>During an interview on 9/9/2020 at 1:25 p.m., LPN Z was asked to review Resident #9's Care Plans with this Surveyor. When asked what Resident #9's current respiratory status was, LPN Z stated, [Resident #9] has pneumonia, and I believe she was just diagnosed with pneumonia. When asked if the care plan reflected Resident #9's prescribed antibiotics for pneumonia, LPN Z, after reviewing the care plans stated, Nope, it is not in here. When asked for the current physician orders for oxygen administration at 3 L, LPN Z reviewed the care plan and stated, No where do I find an order for 3 liters (of oxygen). I have an order for 2 liters, but I see that she is on 3 liters and that is what is also in the care plan for 2 liters. That has never changed since this (pneumonia) started .<br><br>On 9/9/2020 at 1:35 p.m. LPN Z observed Resident #9's level of oxygen administered in the resident's room and found it to be at 3 liters. Resident #9 stated, I have always been on 3 liters (of oxygen), even at home. LPN Z stated, We have a discrepancy between the physician orders at 2L, the care plan at 2L, and the progress notes that say three liters, and the resident receiving 3L O2 (oxygen) per nasal canula. During an interview following this observation, LPN Z stated, I am not seeing any order for three liters (of oxygen). I need to obtain an order for three liters right now. An antibiotic care plan has to be in there right now .<br><br>During an interview on 9/10/20 at 12:35 p.m., with Customer Service Representative (CSR) JJ from [Company Name] that supplied the facility with Resident #9's oxygen concentrator, when asked about Resident #9's concentrator with Serial Number #123539, CSR JJ stated, That is not the concentrator that we show we had delivered to the patient .I don't have any information on that machine . I can't speak for what was there at the [facility] . If it is stored up there for almost two years, we cannot attest to what has gone on with the machine while it has been there.<br><br>35102<br><br>Resident #34<br><br>According to the MDS assessment, dated 7/24/20, Resident #34 was readmitted to the facility on [DATE] with the following applicable diagnoses: pneumonia, anemia, and chronic obstructive pulmonary disease. Resident #34 required one staff assistance for dressing, eating, toilet use, personal hygiene, and bathing. The BIMS score was 15 out of 15, which indicated intact cognition.<br><br>During on observation on 9/2/20 at 1:58 p.m., Resident #34's oxygen was in use at 2 liters per nasal canula (respiratory equipment used to deliver oxygen). The oxygen tubing (to include the green, extension tubing) was undated to indicate the last time it was changed. The water bottle used to provide humidified oxygen was in use and undated.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/3/20 at 8:20 a.m., Resident #34 said he had been on and off antibiotics for respiratory infections in the past. Resident #34 also indicated he received nebulizer treatments routinely and as needed throughout the day.<br><br>During observations on 9/3/20 at 1:50 p.m., on 9/4/20 at 8:30 a.m., and on 9/11/20 at 9:10 a.m., Resident #34's nebulizer mask (equipment used to administer respiratory medications) was observed hanging off the nebulizer machine by way of the mask's green strap with condensation noted in the chamber. The mask was undated.<br><br>Review of Resident #34's Medication Administration Record (MAR) confirmed a respiratory treatment was administered on 9/3/20 at 12:00 p.m., on 9/4/20 at 6:00 a.m., and on 9/11/20 at 6:00 a.m.<br><br>During an interview on 9/4/20 at 1:44 p.m., when asked about the facility's policy regarding nebulizer equipment, the Director of Nursing (DON) said nebulizer equipment needed to be taken apart, rinsed, and placed on a barrier to dry after the respiratory medication has been administered by nursing. The DON confirmed all respiratory equipment needed to be changed weekly and properly labeled. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>35102<br><br>Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent based on 30 errors, out of 56 medication pass opportunities (53.57 %) involving five Residents (#8, #18, #60, #113, and #114) of nine residents observed during medication administration. This deficient practice resulted in the potential for missed medication administration and inaccurate timing administration. Findings include:<br><br>On 9/9/20 at 8:50 a.m., Licensed Practical Nurse (LPN) J opened the top drawer of her medication cart which revealed multiple, small containers which contained various pills within them. Hand-written first names were seen with black ink underneath the inside bottom surface of each paper cup. When asked about the pills in the medication cups, LPN J said she had already prepared the medications for administration for the following Residents: #8, #18, #60, #113, and #114. During Medication Storage review on 9/9/20 at 9:25 a.m. the same residents' medications in the containers were observed as not yet given.<br><br>Review of the Medication Administration Record (MAR) for 9/9/20, revealed medications ordered to be given at 8:00 a.m. on 9/9/20 had already been documented as given by LPN J even though the medications remained in the medication cups.<br><br>Review of Medication Admini (Administration) Audit Report, printed 9/9/20, showed the following medications ordered for 8 a.m. administration:<br><br>Resident #8 medications documental as administered at 8:25 a.m.:<br><br>1.Sertraline HCl 50 mg (milligram) tablets<br><br>2. Centrum Silver one tablet<br><br>Resident #18 medications documented as administered at 7:20 a.m. or 7:23 a.m.:<br><br>3. Micro-K Extended Release 20 mEq (milliequivillant) capsule<br><br>4. Metolazone 2.5 mg tablet<br><br>5. Accupril 40 mg tablet<br><br>6. Metoprolol Tartrate 12.5 mg tablet<br><br>7. Pepcid 20 mg tablet<br><br>8. Isosorbide Mononitrate ER 30 mg (extended release)<br><br>9. Lasix 40 mg tablet<br><br>Resident #60 medications documented as administered at 8:49 a.m., 8:50 a.m., and 8:51 a.m.:<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10. Miralax Powder 17 gram<br><br>11. Acetaminophen 650 mg tablet<br><br>12. Namenda 10 mg tablet<br><br>13. Wellbutrin XL 300 mg ER tablet<br><br>14. Vitamin D3 5000 unit tablet<br><br>15. Triamferene-HCTZ 37.5-25 mg tablet<br><br>16. Mutiple Vitamin tablet<br><br>17. Colace 100 mg tablet<br><br>Resident #113 medications documented as administered at 9:07 a.m. and 9:08 a.m.:<br><br>18. Cholecalciferol 1000 unit tablet<br><br>19. Sucralfate 1 GM (gram) tablet<br><br>20. Glimepiride 1 mg tablet<br><br>21. Sertaline HCl 100 mg tablet<br><br>22. Aspirin 81 mg tablet<br><br>23. Metformin HCl 500 mg<br><br>24. Venlafaxine ER 37.5 mg capsule<br><br>Resident #114 medications documented as adminsitered at 7:12 a.m., 7:13 a.m., 9 a.m., and 9:02 a.m.:<br><br>25. Eliquis 5 mg tablet<br><br>26. Loratadine 10 mg tablet<br><br>27. Aspirin 81 mg tablet<br><br>28. Famotidine 20 mg<br><br>29. Omeprazole 20 mg capsule<br><br>30. Metformin HCl 500 mg<br><br>(continued on next page) |

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| | 235349 | A. Building<br>B. Wing | 09/15/2020 |

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| Mission Point Nsg & Phy Rehab Ctr of Ishpeming | 435 Stoneville Rd<br>Ishpeming, MI 49849 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 9/9/2020 at 2:52 p.m., the Interim Director of Nursing (DON) clarified nurses were expected to document residents' medication administration after the medications had been taken by residents and not before.<br><br>During an interview on 9/9/20 at 4:13 p.m., the Interim DON confirmed it was not acceptable standard of practice for nurses to document medications as administered when they were not administered. The Interim DON said 8:00 a.m. scheduled medications could be administered up to one hour before and up to one hour after (7 a.m. to 9:00 a.m.) the scheduled time to meet the corrct time of medication administration.<br><br>Review of facility's 6.0 General Dose Preparation and Medication Administration revised 1/1/13, read in part, Facility should only prepare medications for one resident at a time . Facility staff should: . Verify each time a medication is administered that it is the .at the correct time . |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>40383<br><br>Based on observation, interview, and record review the facility failed to update, follow, and have all menus with accompanying recipes reviewed by the facility's RD (Registered Dietitian) for all vulnerable residents residing and receiving prepared meals from the dietary department. This deficient practice resulted in the potential nutritional decline by failing to meet the resident's nutritional needs and residents frustrated by the practice of not following menus. Findings include:<br><br>On 09/03/20 at 12:13 PM, the meal trays were observed to have sliced potatoes with a thin watery pink sauce and peas with pearl onions on the plate. There was a slice of bread and a dish of pudding that accompanied the plate. The menu read: Turkey Potato Au Gratin, Peas with Pearl Onions, Wheat Bread and Chocolate Cream Pie. The Dietary Manager (DM) A reported that there was not chocolate cream pie but pudding instead. During meal observations, Resident #18 stated, Today we did not get any meat.<br><br>On 9/03/20 at 12:46 PM, Dietary Staff D was asked about the recipe for the entre. Staff D stated, It is a boxed product. Staff D retrieved an unopened box of scalloped potatoes and said, I made two boxes and added five pounds of smoked turkey. It was in chunks, so I just ground it up. Staff D took the finished product and pureed the mixture for the puree diets. Staff D said, All (60) residents got this except one wanted the alternate. An 8-ounce ladle was observed as the serving size, except for the puree diets were observed to receive a 3-ounce portion.<br><br>Five pounds of smoked turkey meat (80 total ounces) were used for 60 servings. DM A observed approximately four or five servings were left after all the residents had been served. This yielded approximately 1.25 ounces of meat for each resident (8 ounce serving) and less than a half ounce of meat for the residents receiving pureed diets. Staff A produced the recipe for the puree turkey scalloped potatoes, which did not include using a boxed dehydrated product. The pureed recipe indicated that residents should have also received servings of 8 ounces (the same as all other residents were directed to receive.) When asked how much protein should be served, DM A stated she was unsure, but would find the answer.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 09/03/20 at 1:46 PM, the current menus titled Senior Living F/W (Fall/Winter) Midwest 2019 were reviewed. The facility name was listed on the bottom of the menu, but no RD signature/date of review was present on the general menu or special diet menu extensions. The menu spread sheet extensions which indicated what food to serve and the portion sizes for those residents on special diets including puree diets were dated Thursday 10/3/2019 and were not available for the kitchen staff to use. DM A said, I have them (the extended menus for the diets other than regular) but have not put them in the kitchen yet. Staff A reported that the signed copies of the menu were in the front office. Staff A retrieved menus signed by RD B which were titled with the facility name. This set of menus did not list the special diets and had no lunch meal with the items that had been served as observed on Thursday 9/3/20. The menu for Monday 9/3 was listed as Baked Spaghetti with Cauliflower, Garlic Toast and Diced Pears. On 9/10/20 at 1:50 PM, RD B stated in a phone conversation that she had reviewed the menus and signed them. RD B stated, I only received the week at a glance (the menu for the regular diet) . RD B said she had not been asked to review the menu extensions for the special diets and had not looked at the recipes. RD B stated I have looked at recipes if the dietary manager asks . I do not have any tasks in the kitchen. RD B said she did not watch the tray line or observe the meal preparation in the kitchen.<br><br>On 9/03/20 at 7:44AM, the breakfast meal was observed and included brown sugar on each serving of oatmeal. Again on 9/10/20 at 8:39AM, the breakfast meal was observed, and a test tray was requested. The test tray included oatmeal with brown sugar on top. DM A stated approximately one ounce of brown sugar was added to each serving of oatmeal and confirmed the scoop size used by the cook. DM A stated All the residents get brown sugar in their oatmeal, unless they do not like it. DM A confirmed this included the carbohydrate controlled diets (used for residents with diagnoses such as diabetes mellitus), and stated, They probably should not.<br><br>On 9/9/20 at 9:19AM, DM A stated that the carbohydrate controlled diet was used to keep an eye on their (the residents) carbohydrates . I do not know why. DM A listed foods high in carbohydrate as potatoes, bread, rolls, and rice . So on this diet (carbohydrate controlled) you cut back on them.<br><br>On 09/09/20 at 01:34 PM, the DM A stated, I came June 6th (2020) and have just started taking the dietary manager class. The dietary manager class syllabus was reviewed, and it was observed that there were 3 units with 5 lessons each (Unit 1 was on food preparation and storage. Unit 2 was on food service management. Unit 3 was on nutrition and medical nutrition therapy.) DM A had finished one lesson from the first unit. DM A had minimal contact with RD B and stated, I think she works remotely; I have not seen her since I started.<br><br>During the phone conversation on 9/10/20 at 1:50 PM, RD B stated, Carb (carbohydrate) controlled diets should not receive brown sugar in their oatmeal. RD B said the resident on a Carb controlled diet would not routinely receive brown sugar. If they did not want a sugar sub, we would get the OK from the doctor and get the OK for the care plan.<br><br>This had not been the case. RD B stated, I do preceptor DM A for the dietary manager class and talk to her on the phone . The quarterly assessments and the annuals are done by (DM A). She is a CNA (Certified Nurse Aid) . She (DM A) has only called me one time since she has started. I have offered my assistance, but I have not heard what she would like assistance with. RD B was unaware that the facility was serving brown sugar with the hot cereal daily. RD B confirmed she had not been in the facility since approximately March of 2020.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 9/11/20 at 09:51 AM, the facility Diet Manual was reviewed. The description of the Consistent Carbohydrate Diet read in part, Foods to Limit . High sugar foods (cake, cookies, candy, sugar, regular soda pop). The recipes for Cereal Hot Choice Pureed and Cereal Choice of were reviewed and did not include brown or white sugar.<br><br>On 9/4/20 at 10:50AM, DM A delivered the facility policy titled: Dietary Menus which was undated as to initiation or revision date. It read in part: The facility will use and follow the (Vendor Name) Cycle Menu Management System menus . in order to provide the residents with proper and balanced nutrition according to their therapeutic needs . The current 5-week cycle menu from (Vendor Name) will be used and followed by the facility . The therapeutic spreadsheets (menu extensions) for the menu cycle will be used and followed by dietary staff to meet resident needs . The RD will review all menu (sic) for nutritional appropriateness prior to starting each new menu cycle.<br><br>The Dietitian Job Description for RD B with a date of hire of 07/12/18 was reviewed and read in part: The primary purpose of your job description is to plan, organize, develop and direct the overall operation of the Food Services Department. The Duties and Responsibilities section included, Assist in planning regular and special diet menus as prescribed by the attending physician . Assist the Director of Food Services (DM A) in planning menus . Review therapeutic and regular diet plans and menus to assure they are in compliance with the physician's orders. Assist in developing methods for determining quality and quantity of food served . This document had space for acknowledgement by the RD and the Administrator. Both areas for the RD and for the Administrator were unsigned and undated. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383<br><br>Based on observation, interview, and record review, the facility failed to serve meals that were palatable, attractive and at appetizing temperatures for all vulnerable residents residing and receiving prepared meals from the dietary department. This deficient practice resulted in dissatisfied residents and the increased likelihood for decreased resident food acceptance and nutritional decline. Findings include:<br><br>On 09/02/20 at 2:06PM, Resident #18 stated, The soup was cold today. It is the kind that comes in a can and it was not even mixed after they added the water . The food is not consistent .The ham is cooked in water and has no taste. The vegetables have no sauce . I have talked to the kitchen. On 09/03/20 at 12:13 PM, the meal trays were observed to have sliced potatoes with a thin watery pink sauce and peas with pearl onions on the plate. There was a slice of bread and a dish of pudding that accompanied the plate. The menu read: Turkey Potato Au Gratin, Peas with Pearl Onions, Wheat Bread and Chocolate Cream Pie. Resident #18 stated, The food is warm today, but it is usually cold . you should see it on Saturday and Sunday . Today we did not get any meat. A review of the medical record for Resident #18 revealed the Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated Resident #18 was cognitively intact.<br><br>On 9/10/20 at 8:39AM, Resident #26 stated, I wish the food had more spice. The breakfast trays were observed to be without salt or pepper. The Dietary Manager, (DM) A obtained both salt and pepper from the top of the food cart after Resident #26 requested it. DM A said that the standard was to place salt and pepper on the resident's tray if the diet allowed. This had not occurred. A review of the medical record for Resident #26 revealed the MDS assessment dated [DATE] included a BIMS score of 15 out of 15 which indicated Resident #26 was cognitively intact.<br><br>On 9/10/20, at approximately 9:45AM, Resident #16 stated that she requested salads and food she would like from the kitchen. A bowl of salt and pepper packets was observed on Resident #16's bedside table. Resident #16 remarked that the trays often did not have salt and pepper and the food needed more seasoning. A review of the medical record for Resident #16 revealed the MDS assessment dated [DATE] included a BIMS score of 15 out of 15 which indicated Resident #16 was cognitively intact.<br><br>On 9/10/20 at 8:50 AM, the breakfast meal was observed, and DM A took temperatures of the test tray that had been sent to the 300 hall. The temperatures were as follows:<br><br>cheese eggs: 110 degrees Fahrenheit*<br><br>orange juice: 52 degrees Fahrenheit*<br><br>oatmeal with brown sugar: 146 degrees Fahrenheit<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (*) The 2013 FDA Model Food Code section 3-501.16 states: (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 57oC (135oF) 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 54oC (130oF) or above; or (2) At 5 C (41 F) or less.<br><br>On 09/09/20 at 01:34 PM, DM A stated that she started her position as Dietary Manager on 06/06/20 and had just started taking the dietary manager class which had 15 lessons. DMA had finished one lesson. When asked about Registered Dietitian (RD) support, DM A said she had minimal contact with RD B and stated, I think she works remotely; I have not seen her since I started.<br><br>On 9/10/20 at 1:50 PM, RD B stated in a phone conversation, I do not have any tasks in the kitchen. RD B said she did not watch the tray line or observe the meal preparation in the kitchen. RD B stated, I usually would talk to residents about the food . I have not received any requests from the staff to speak to any of the residents. RD B confirmed she had not been in the facility since approximately March of 2020.<br><br>The Dietitian Job Description for RD B with a date of hire of 07/12/18 was reviewed and read in part: The primary purpose of your job description is to plan, organize, develop and direct the overall operation of the Food Services Department. The Duties and Responsibilities section included, Assume the administrative authority, responsibility and accountability of directing the Food Services Department . Plan, develop, organize, implement, evaluate and direct our facility's Food Services Department, its programs and activities . Coordinate food service activities . Assist in developing methods for determining quality and quantity of food served . Visit residents periodically to evaluate the quality of meals served . This document had space for acknowledgement by the RD and the Administrator. Both areas for the RD and for the Administrator were unsigned and undated.<br><br>35103<br><br>During an interview on 9/2/2020 at 2:32 p.m., when asked if she enjoyed the food served by the facility, Resident #9, who was cognitively intact per the Brief Interview for Mental Status (BIMS) stated, The food is awful. It is so bland .<br><br>During an interview on 93//2020 at 2:23 p.m., when asked about food provided by the facility, Resident #4, who was cognitively intact, stated, Lunch today was terrible. It was scalloped potatoes and peas. I don't think it had any meat. It did not taste very good.<br><br>During an interview on 9/4/2020 at 8:22 a.m., when asked about the breakfast he was eating at that time, Resident #4 stated, No, (the) eggs were not warm. They were cold when I got them.<br><br>During an interview on 9/4/2020 at 8:25 a.m., when asked breakfast had tasted Resident #9 stated, Breakfast was cold and watery. They (eggs) weren't warm.<br><br>Review of Resident Council and Food Council meeting minutes revealed residents had expressed concerns related to cold food and lack of timely meal delivery in June, July, August and September of 2020. |

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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>40383<br><br>Based on observation, interview and record review, the facility failed to store, prepare and serve food in accordance with professional standards for food service safety as evidenced by:<br><br>1. Failing to ensure food contact surfaces were properly sanitized when using the kitchen sanitizing solution buckets and cleaning cloths for this function.<br><br>2. Failing to effectively date mark and store potentially hazardous ready-to-eat food products.<br><br>3. Failing to effectively maintain and clean food service equipment.<br><br>These deficient practices have the potential to result in food borne illness among any or all the 62 residents of the facility.<br><br>Findings include:<br><br>1.On 9/2/20 at 1:20PM, Dietary Manager (DM) A tested the red sanitizing bucket used for cleaning cloths. It registered zero ppm (parts per million) which indicated the solution in the bucket had no sanitizer. Dietary Staff C said I just filled that bucket which was noted to have cleaning cloths immersed. Staff C then re-tested the same bucket and again the measuring strip registered zero. Another red sanitizing bucket in the dish machine area was tested by DM A. It also registered zero ppm. The sanitizer dispensing equipment was inspected and the sanitizer was nearly empty and was not dispensing when buckets were filled. The staff were unaware that the buckets had no ability to kill germs.<br><br>The FDA Food Code 2013 states:<br><br>4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization Temperature, pH, Concentration, and Hardness.<br><br>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 S7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows:<br><br>(C) A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24oC (75oF),<br><br>(2) Have a concentration as specified under S 7-204.11 and as indicated by the manufacturer's use directions included in the labeling<br><br>2.On 9/2/20 at 1:20PM, an initial tour of the food service was conducted with Dietary Manager (DM) A. The following items were noted:<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 | The walk-in refrigerator had a Purple passion monster beverage which was open, half full and had no label or date. A mountain dew was open, half full and had no label or date. On 9/9/20 at 8:06AM, observations in the kitchen included the walk-in refrigerator with the following items out of date:<br><br>- tomato juice was labeled with an opened date of 8/13/20 and a use by date of 8/18/20<br><br>- prune juice was labeled with an opened date of 9/1/20 and a use by date of 9/5/20<br><br>- soy silk milk was opened and undated<br><br>- breakfast ham was labeled with prepared date of 9/3/20 and a use by date of 9/8/20<br><br>A case of scrambled eggs in cartons were observed to be stored on the walk-in refrigerator floor.<br><br>The 2013 FDA Model Food Code section 3-501.17 states: (A) Refrigerated Ready-to-Eat 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 41 degrees Fahrenheit or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.<br><br>3. On 9/2/20 at 1:20PM, the dry storeroom was noted to have a thickening agent stored in a bin with an approximate 8 inch x10 inch hole in the back. The thickener was stored in an open plastic bag inside the bin and was not secured. On 9/9/20 at 8:06AM, the grill and oven hood system had a grease drain which was missing a drip pan. There was a large #10 can with a label of sweet peas sitting on the floor under the overhead hood with a brown murky liquid covering the bottom. Nine overhead lights were not functioning to capacity (either partially lit or not working at all). One light did not have a cover. The light over the tray line had a large amber stain. DM A produced a daily cleaning checklist for the month of August (the current month of September could not be found). The August cleaning checklist for dietary staff position #1 and #2 was blank and was partially completed for dietary staff position #3 and PM cook.<br><br>The 2013 FDA Model Food Code section 6-501.12 states: (A) Physical Facilities shall be cleaned as often as necessary to keep them clean.<br><br>On 9/02/20 at 1:15 PM, DM A stated she started this position 06/06/20, and she was not a Certified Dietary Manager, but was enrolled in the certification class. DM A stated, There is an RD, (Registered Dietitian) but I have not seen her since I started. DM A indicated that RD B was the preceptor assisting DM A with her classes.<br><br>On 9/10/20 at 1:50 PM, RD B stated in a phone conversation, I do not have any tasks in the kitchen. RD B said she did not watch the tray line or observe the meal preparation in the kitchen. RD B confirmed she had not been in the facility since approximately March of 2020.<br><br>On 9/3/20 at 2:00PM, the policy titled: Three Compartment Sink Inservice was received from DM A as current. The policy was undated as to implementation or review. It read in part: Each time the sanitizer buckets for cleaning cloths are refilled, the concentration of the sanitizer must be measured and recorded . The sanitizer should measure - 200 ppm for a quaternary sanitizer.<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 | On 9/9/20 at 1:00PM, the policy and procedure titled, Handling and Storage of Refrigerated Foods and dated as effective 11/30/2014 was delivered by DM A. It read in part: All leftovers should be labeled, dated and used within three days.<br><br>On 9/9/20 at 1:00PM, the policy and procedure titled, Light Covers and dated as effective 01/2007 was received from DM A. It read in part: Light covers will be clean and sanitized according to established standards. The top of the copied policy had handwriting of Weekly in the upper left hand corner.<br><br>The Dietitian Job Description for RD B with a date of hire of 07/12/18 was reviewed and read in part: The primary purpose of your job description is to plan, organize, develop and direct the overall operation of the Food Services Department. The Duties and Responsibilities section included, Assume the administrative authority, responsibility and accountability of directing the Food Services Department . Be sure that food service personnel are performing required duties and that appropriate food service procedures are being rendered to meet the needs of the facility . Ensure that food service work areas are maintained in a clean and sanitary manner . Ensure that food storage rooms, preparation areas, etc are maintained in a clean, safe and sanitary manner . Make periodic rounds to inspect equipment and to assure that necessary equipment is available and working properly . Working condition expectations included: Works in office areas as well as throughout the facility's food service areas. This document had space for acknowledgement by the RD and the Administrator. Both areas for the RD and for the Administrator were unsigned and undated. |

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| | 235349 | A. Building<br>B. Wing | 09/15/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Point Nsg & Phy Rehab Ctr of Ishpeming | 435 Stoneville Rd<br>Ishpeming, MI 49849 |

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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** 35102<br><br>Based on observation, interview, and record review, the facility failed to maintain infection control program practices to prevent potential spread of infectious organisms including COVID-19 (a highly transmissable viral infection). This deficient practice resulted in the potential for transmission of communicable diseases which had the potential to affect all 60 residents residing in the facility. This deficient practice has eight noted deficiencies:<br><br>1. Failed to ensure safe entrance screening (staff/visitor) to prevent transmission of COVID-19.<br><br>2. Failed to complete timely infection control surveillance and infection mapping.<br><br>3. Failed to perform facility COVID-19 specimen collection per Centers for Disease Control and Prevention (CDC) guidelines.<br><br>4. Failed to appropriately use Personal Protective Equipment (PPE) related to COVID-19 isolation.<br><br>5. Failed maintain isolation precautions to prevent the transmission of COVID-19.<br><br>6. Failed to perform appropriate hand hygiene.<br><br>7. Failure to maintain aseptic technique during wound care.<br><br>8. Failed to follow facility Novel Coronavirus Prevention and Response, policy, date revised 5/12/20, to regards to continued acceptance of new resident admissions.<br><br>Findings include:<br><br>On 9/2/20 at 12:10 p.m., Transporter (Staff) EE was observed pushing Resident #41 in her wheelchair from the facility's transportation van into the facility. Staff EE's facemask was positioned underneath her nose. Resident #41 was not wearing a facemask. While the Surveyors were in the vestibule, Staff EE and Resident #41 entered without adherence to social distancing. The vestibule did not contain hand sanitizer nor facemasks. The screening station was located inside the facility through another set of doors where other unidentified residents were in the immediate vicinity.<br><br>During an interview on 9/4/20 at 1:40 p.m., the Director of Nursing (DON) was asked about the posted signage indicating the need for wearing a facemask within the building. The DON said staff were expected to wear facemasks when entering the building through the first set of doors which lead into the vestibule. When asked why the hand sanitizer and facemasks were located after the vestibule, through the second set of doors, the DON said it was an administration decision and understood the discrepancy and need for the supplies to be made available upon initial entrance. When asked about staff PPE use with the transportation of residents, the DON said staff were always required to wear facemasks (to cover both the nose and mouth). The DON said residents were only encouraged, but not required, to wear facemasks.<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 the same interview on 9/4/20 at 1:40 p.m., the DON and the Infection Preventionist, Licensed Practical Nurse (LPN) K were asked to provide infection control surveillance and mapping for August and September 2020. LPN K said she did not have any infection control surveillance and mapping for September (2020). Initial tour of the facility on 9/2/20 at 12:15 p.m. showed seven rooms had isolation precautions in place. The DON said after reviewing August 2020 Infection Control Log (8/1/20 to 8/31/20) that several residents were omitted who had infections and that the log was not updated to include isolation precautions currently in place.<br><br>Review of the signage on Resident #41's door read:<br><br>STOP SPECIAL DROPLET/CONTACT PRECAUTIONS STOP .Everyone Must: Including visitors, doctors & staff<br><br>Clean hands when entering and leaving room<br><br>Wear face mask<br><br>Wear eye protection (face shield or goggles)<br><br>Gown and glove at door .<br><br>KEEP DOOR CLOSED .<br><br>Observation of isolation room doors on 9/2/20 at 3:20 p.m., found doors on Rooms #109, #204, #410, #413, and #414 wide open. All doors contained the above Contact/Droplet Precaution signage to Keep Door Closed.<br><br>On 9/3/20 at 4:00 p.m., during a medication pass observation, LPN JJ put on a clean gown and pair of gloves but had not changed the surgical mask worn prior to entering Resident #41's Contact/Droplet Precaution isolation room. LPN JJ did not wear a face shield or goggles as indicated. Resident #41's door was found wide opened. LPN JJ when asked about the face shield requirement for entering Resident #41's room, responded, This is all we wear and then pointed to her face mask. LPN JJ used a blood glucose monitor (shared piece of medical equipment) for Resident #41. After use, the monitor was then wrapped in a paper towel and removed from Resident #41's room by LPN JJ. No cleaning and disinfecting supplies were located within the room nor in the isolation supply bin outside of Resident #41's room. LPN JJ indicated the blood glucose machine was returned to the medication cart located on another hallway where it was then cleaned/disinfected.<br><br>35103<br><br>During observations on the 300 hall on 9/3/20, breakfast trays were delivered to Residents #4, #21, #48, and #9, at 7:58 a.m., 8:00 a.m., 8:02 a.m., and 8:04 a.m., respectively. Observations revealed facility staff did not assist these Residents with hand hygiene prior to the breakfast meal, nor did staff ask if Residents wanted to perform hand hygiene prior to eating.<br><br>During an interview on 9/3/20 at 8:08 a.m., when asked if the opportunity for hand hygiene prior to meals was routinely offered, cognitively intact Resident #9, stated, No.<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 | On 9/3/20 at 8:15 a.m., Laundry (Staff) NN was observed walking down the 300 hall with her mask beneath her nose. Upon observation of this Surveyor, Staff NN pulled her facemask up to cover her nose using her bare hand on the front of the mask. No hand hygiene was observed following replacement of Staff NN's facemask. During an interview at this time, when asked about the position of her facemask Staff NN stated, My nose was out.<br><br>On 9/3/20 at 8:20 a.m., a wound care observation of Resident #48 was conducted. LPN T was already present in the room with wound care supplies when this Surveyor entered the room. Wound care supplies were placed on the overbed table, directly on top of a soiled handkerchief, television remote, a comb, and miscellaneous papers. The overbed table did not contain a barrier to prevent contamination of the clean dressing supplies. Upon entrance of this Surveyor, LPN T removed the soiled handkerchief, television remote, comb, and papers leaving the dressing packages on the overbed table. LPN T exited the room and returned to Resident # 48's room with a towel. LPN T gathered the dressing supplies from the overbed table and placed the wound care supplies and towel on top of a pair of Resident #48's dirty sweatpants and shoes, setting on the bedside table. LPN T washed his hands in the resident's bathroom and shut the room door using his bare hand. The overbed table was sanitized, and the dirty towel (from on top of clothes on the bedside table) was used as a barrier on the overbed table. The wound care supplies were placed on top of the dirty towel. Following completion of the wound care, hand hygiene was performed. LPN T touched the front of his facemask with his bare hand, then used the same bare hand to open Resident #48's room door. LPN T pulled his facemask away from his face, with a bare hand, to talk and exited the room. No hand sanitation was observed following touching of the facemask.<br><br>During an interview on 9/3/20 at 8:45 a.m., LPN T was asked about preparation of wound care supplies on the cluttered and soiled overbed table prior to this Surveyor's entrance into Resident #48's room. LPN T stated, They clean wound dressing supplies) should not have been on there. LPN T confirmed that the towel barrier and dressings had been placed on Resident #48's dirty clothes on the bedside table. LPN T also agreed he had pulled his potentially soiled facemask out with his bare right hand and then opened the room door to exit with the same right hand. LPN T agreed the front of the facemask is potentially the most contaminated surface of the mask.<br><br>On 9/3/20 at 1:00 p.m., the DON was observed in the front office of the facility wearing a face shield, with a surgical mask pulled down under her chin. The DON confirmed the front office was being used this day (9/3/20) for staff COVID-19 specimen collection. Several unidentified staff members present in the front office during this observation were eating, with their masks under their chins, or no mask at all. During an interview at this same time, the DON said she was obtaining COVID-19 specimens from facility staff. When asked if the facility was, or needed to conserve PPE, Maintenance Director X stated, No, we have lots of N95 masks. When asked about the absence of an N95 respirator for COVID-19 specimen collection the DON said only surgical masks with eye protection were worn for COVID-19 specimen collection and care of residents in isolation/observation for COVID-19. The DON stated it was per corporate policy.<br><br>Review of the CDC Performing Broad-Based Testing for SARS-CoV-2 (COVID-19) in Congregate Settings, updated June 27, 2020, revealed the following, in part: Gown, N95 equivalent or higher-level respirator . gloves, and eye protection are needed for staff collecting specimens or working within 6 feet of the person being tested .<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 9/4/2020 at approximately 2:45 p.m., when asked who was present in the front office at the time of this Surveyor's observation on that day, the DON confirmed she was present, as well as Registered Nurse (RN)/Assistant Director of Nursing (ADON) OO, Clinical Support RN BB, and LPN/MDS/Wound Care Z. When asked about the signage, highlighted in yellow on the outer facility door that stated, ALL STAFF AND HEALTHCARE PROFESSIONALS ENTERING THE BUILDING MUST WEAR A FACE MASK THE ENTIRE TIME THEY ARE IN THE BUILDING . the DON said there were no exceptions to who should be wearing a mask at all times. The DON stated, Physical Therapy has to wear (a) mask. Any of our staff have to wear a mask. When asked if wearing a mask at all times while in the building applied to staff in the front office who were observed with their facemasks under their chins, the DON confirmed the sign was applicable to all staff. Regarding the process of testing staff for COVID-19, the DON confirmed she was collecting the COVID-19 specimens with oral swabs, and stated, I was wearing a surgical mask and a face shield . If they (staff) are not working we are checking their temp (temperature), and if they are asymptomatic, we continue (testing) with the surgical mask and the face shield.<br><br>Review of the CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, Updated June 25, 2020, revealed the following, in part: . Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown . HCP (Health Care Provider) should wear an N95 or higher-level respirator (personal protective device that . covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors) . eye protection (i.e., goggles or face shield that covers the front and sides of the face), gloves, and gown when caring for these residents .<br><br>Review of the facility Coronavirus Testing policy, Date Implemented: 9/1/2020, revealed the following, in part: Specimens (for Covid-19 testing) will be collected .The facility will maintain proper infection control and use recommended personal protective equipment (PPE) per CDC guidance .<br><br>On 9/4/2020 at 12:05 p.m., Therapy Staff LL and MM were observed sitting in front of their computers in the facility therapy room with their facemasks positioned under their chins. The door to the therapy room was wide open. When this Surveyor was observed, both staff members moved their facemasks up, to cover their nose and mouth.<br><br>On 9/4/2020 at 3:25 p.m., LPN Z was observed in the facility front office, at the computer, with her facemask beneath her nose.<br><br>On 9/9/2020 at 9:08 a.m., CNA CC was observed exiting room [ROOM NUMBER] (a COVID-19 14-day observation room) with a clear garbage bag, with PPE (blue isolation gown and other soiled (used) PPE) visible inside the bag. CNA CC tied the bag shut with her bare hands after exiting room [ROOM NUMBER]. CNA CC then used her bare hands to open the clean PPE cart outside of room [ROOM NUMBER]. During an interview at this same time, when asked if the garbage bag contained clean or dirty PPE, CNA CC confirmed it was dirty, and acknowledged she had opened up the clean PPE cart with her dirty hands, and retrieved and donned a clean surgical mask with dirty hands.<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 | On 9/9/2020 at 2:08 p.m., Activity Aide (Staff) DD was observed exiting room [ROOM NUMBER] (a COVID-19 14-day observation room). Staff DD exited the room, stood next to the clean PPE cart, and removed her dirty surgical mask with bare hands. Without hand hygiene, Staff DD used her same bare hands to open the clean PPE bin outside of room [ROOM NUMBER], touched the clean surgical mask with soiled hands, and disposed of the dirty mask inside room [ROOM NUMBER]. Staff DD walked across the hall and used her same dirty hands to open the clean PPE bin across the hall from room [ROOM NUMBER] and removed and began to don a clean isolation gown from that PPE bin. During an interview at this same time, Staff DD confirmed she had used dirty hands to access all clean PPE and acknowledge she should have performed hand hygiene prior to donning clean PPE.<br><br>During an interview on 9/4/20 at approximately 2:50 p.m., after discussion of infection control observation concerns the DON was asked about the facility's continued acceptance of new admissions requiring COVID-19 quarantine precautions. The DON stated, We have had staffing difficulties. We have continued to take admissions. I completely - 100% agree that we should have stopped admissions until we could get our staff under control. Pretty much we have nurses on the floor as CNAs every day. When asked to clarify, the DON said she had communicated her concerns regarding insufficient staff to meet the demands required for continued acceptance of new admissions.<br><br>Review of the facility Novel Coronavirus Prevention and Response, revised 5/12/2020 read in part: Considerations for admitting residents with suspected or confirmed COVID-19: .Do not admit if the facility is unable to meet the level of care needs or the requirements for transmission-based precautions.<br><br>40383<br><br>On 09/03/20 at 9:37 AM, room [ROOM NUMBER] was observed to have residents who required droplet precautions (which indicated a potential for infections with germs spread by speaking, sneezing or coughing). The droplet precautions notice was taped to the open door. Seven minutes later at 9:42 AM, RN G entered room [ROOM NUMBER]. She had donned a gown, mask and gloves, but not a face shield. The droplet precaution instructions posted on the door indicated a face shield or goggles were required. RN G stated, We have just been wearing masks . I did not wear a face shield.<br><br>On 09/03/20 at 9:49 AM, Housekeeper F was observed entering room [ROOM NUMBER] which required droplet precautions. She carried a container for dirty laundry into the room and did not don a gown, goggles or face shield. When Staff F exited the room, she stated, I am sorry. It has been a very busy day. I should have put on goggles, gown, and the whole 9 yards, but I didn't. |