STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235349	A. Building B. Wing	04/05/2023

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 40383 Based on observation, interview, and record review, the facility failed to ensure the results of the most recent state surveys and corresponding plans of correction were readily accessible to all Residents in the facility. This deficient practice resulted in the potential for all 44 Residents and Resident Representatives to be uninformed of identified deficiencies and solutions as written in the plan of correction. Findings include: On 4/03/23 at 1:30 PM, a confidential group meeting was held with 10 Residents. The consensus of the group was they did not know the results of past surveys or where the results and plans of correction were posted in the building. They stated they would like to be able to read the results. On 4/04/23 at 11:25 AM, the public posting binder was observed in the entry hallway. There was a survey in this binder dated 1/25/22, with a SUMMARY STATEMENT OF DEFICIENCIES. The plan of correction and completion dates were not listed. The most recent survey with approximately 184 pages of concerns and the plan of correction from 1/18/23 was not in this survey binder. During an interview with the Nursing Home Administrator on 4/04/23 at 1:27 PM, he reviewed the binder and agreed the surveys and plans of correction were not posted.

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41978 Based on observation, interview and record review, the facility failed to ensure documentation of self-administered inhaled medications according to facility policy and professional standards of practice for one Resident (R33) of one Resident reviewed for medication self-administration. This deficient practice resulted in the potential for unmet care needs. Findings include: An observation on 4/04/2023 at 4:32 p.m., revealed R33 sitting in bed wearing a nasal cannula (device used to deliver supplemental oxygen through prongs placed in the nostrils) and tubing leading to a portable oxygen concentrator set to deliver three liters of oxygen per minute (3L/min). R33 reported she had chronic obstructive pulmonary disease (COPD) and required continuous supplemental oxygen use. Further observation revealed an inhaler containing albuterol sulfate 108 mcg (microgram) solution, lying on a bedside table directly to the right of the resident's bed. The inhaler was observed have 31 doses remaining of the original 200 doses per the inhaler packaging. R33 reported self-administering the medication daily when she felt short of breath. R33 stated staff were aware of her use of the medication. During an interview on 4/4/2023 at 4:35 p.m., Licensed Practical Nurse (LPN) V reported she often cared for R33 and was assigned to care for R33 on the current shift. LPN V stated she was unaware R33 had an albuterol inhaler in her room for self-administration or that R33 regularly used the medication. A review of R33's physician orders revealed the following: Order Date: 7/3/2020, 11:16 [a.m.]. Medication: [albuterol sulfate HFA aerosol solution 108 MCG/ACT, brand name redacted] . 2 puff inhale orally every 4 hours as needed for shortness of breath related to chronic obstructive pulmonary disease (acute) with exacerbation. May keep at bedside. A review of R33's Medication Administration Records (MARs) for January 2023 through April 4, 2023, revealed no recorded doses administered by staff or recorded self-administered doses of the albuterol inhaler R33 kept at her bedside. During an interview on 4/4/2023 at 5:10 p.m., the Director of Nursing (DON) reported nursing should inquire as to when Residents self-administer medications and record the administration on the MAR. The DON acknowledged the physician uses the MAR to determine care needs including changes to medication regimens. The DON confirmed without documentation of R33's use of the albuterol inhaler, the physician and care team may not recognize if the Resident is overusing the medication or if supplemental medications are needed. A review of the facility policy titled Resident Self-Administration of Medication, last reviewed 12/2020, revealed the following, in part: 5. Upon notification of the use of bedside medication by the resident, the medication nurse records the self-administration on the MAR/TAR [Treatment Administration Record].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to ensure residents were free from the development of avoidable pressure ulcers for one Resident (R8) of three residents reviewed for pressure ulcers. This deficient practice resulted in harm when R8 developed a Stage 4 [full thickness tissue loss exposing muscle, ligament and/or bone] right buttock pressure ulcer and the potential for worsening of existing wounds. Findings include: R8 was admitted to the facility on [DATE] and had diagnoses including paraplegia (paralysis of the lower extremities), peripheral vascular disease and generalized weakness. A review of R8's admission Minimum Data Set (MDS) assessment, dated 8/11/2022, revealed the Resident required extensive, two-person physical assistance with bed mobility and was totally dependent on staff for transfers. A review of the MDS Section M - Skin Conditions, revealed R8 was assessed as being at risk for developing pressure ulcers and as having two Stage 4(full-thickness skin loss exposing muscle, tendon, cartilage, or bone) pressure ulcers upon admission. It was noted in review of Section M of R8's admission MDS assessment, the Resident was assessed as having no Stage 1, 2 or 3 pressure ulcers. A review of R8's most recent, completed MDS assessment, dated 2/11/2023, revealed R8 continued to require two-person, physical assistance with bed mobility and he remained dependent on staff for transfers. Further review of the MDS assessment, dated 2/11/2023, revealed R8 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he was cognitively intact. It was noted in review of all R8's MDS assessments, dated 8/11/2022, 9/30/2022, 10/06/2022, 1013/2022, 11/11/2022, 11/17/2022 and 2/11/2023, Section G - Behavior . E08.00 Rejection of Care - Presence & Frequency, R8 was assessed as 0 - Behavior not exhibited. An observation of R8's wound care, provided by Licensed Practical Nurse (LPN) K on 4/03/2023 at 5:00 p.m. , revealed R8 was receiving wound VAC [Vacuum-Assisted Closure, used to decrease air pressure around a wound to aid in healing] treatment for wounds on his sacrum and right buttock. R8 also had intact dressings located on his right greater trochanter (outer hip area) and the left ischial tuberosity (sit bone). Upon removal of R8's wound dressing, the following was observed: One round pressure ulcer, approximately 3 centimeters [cm] in diameter, over R8's right outer hip. The wound was approximately 90% covered with yellow/tan colored slough (dead tissue); one pressure ulcer located over R8's left sit bone (ischial tuberosity) extending down to the perineum (area between anus and scrotum), approximately 7 cm long by 4 centimeter wide by 1 cm deep. The wound appeared deep and the wound bed was unable to be visualized; one wound located over R8's sacrum (triangular bone as base of spine), triangular in shape, approximately 6 cm long by 5 cm wide by 2 cm deep, with a red/pink wound bed, and; one wound located on R8's right buttock near the sacrum, oblong in shape and approximately 7.5 cm long by 1 cm wide by 1 cm deep, with a red/pink wound bed. During the observation, LPN K reported R8 had the sacral and left ischial wounds upon admission to the facility. LPN K stated the right buttock wound appeared after R8 had slept one night with the air mattress turned off. LPN K stated he was unsure of when the event occurred but nursing now had a task every shift to check the air mattress for proper functioning. LPN K reported he assumed the role of wound care nurse three weeks prior to the observation of R8's wound care on 4/03/2023. Further observation revealed the air mattress control panel attached to the end of R8's bed was out of sight and reach of the Resident. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R8's electronic medical record (EMR) revealed wound care documentation of R8's right buttock wound began on 1/17/2023. Further review revealed the following: 1/17/2023, 23:16 [11:16 p.m.] Weekly Wound Note: Sacrum DTI [deep tissue injury, damage to underlying tissue due to prolonged pressure], 12 [cm] x 3.5 cm. non-blanchable purple discoloration, blanchable deep red discoloration with shearing. Scan amount of serosanguineous drainage on bed pad . irregular wound edges, attached . new wound. 1/27/2023, 14:21 [2:21 p.m.] Weekly Wound Note: Sacrum/right buttock unstageable pressure injury, 12.0 [cm] x 2.3 [cm], 70% soft brown eschar [dead tissue] center of wound measuring 8.0 [cm] x 1.5 [cm], 10% of wound is red non-granular tissue, 20% slough . 2/3/2023, 20:00 [8:00 p.m.], Weekly wound Note: Sacrum/right buttock unstageable pressure ulcer, 11.0 [cm] x 2.5 [cm] x 3.5 [cm], 100% yellow slough, moderate amount of sanguineous drainage, wound edges: unattached . wound care clinic removed all eschar from wound . 2/11/2023, 12:09 [12:09 p.m.], Weekly Wound Note: Sacrum/right buttock unstageable pressure ulcer, 10.5 [cm] x 2.0 [cm] x 3.5 [cm], 90% yellow slough 10% red tissue . 2/24/2023, 16:51 [4:51 p.m.], Weekly Wound Note: Right buttock stage IV (4) pressure ulcer, 8.0 [cm] x 1.8 [cm] x 2.8 [cm], 80% red tissue with 20% slough, moderate sanguineous drainage in wound vac canister . wound vac applied per wound care clinic orders . Further review of R8's EMR revealed the following Nursing Progress Note, dated 1/17/2023 at 7:00 p.m.: Resident at 1500 [3:00 p.m.] was noted to be lying in bed with air mattress deflated r/t [related to] switch being turned to off . Resident unaware air mattress was not on . A review of R8's wound clinic Progress Note Details, dated 3/02/2023, revealed the following, in part: 1/25/22 - The patient returns to the clinic after 1 month with a new large right buttock unstageable pressure ulcer . wounds are debrided today with the exception of the new ulcer that is dry eschar/necrotic covered. The patient reports that his alternating pressure mattress accidentally got shut off one night and he was basically lying on the bed frame for some time. He does not know for exactly how long as he woke that way in the morning . Plan: . Wound #7 Right Buttock . Negative Pressure Wound Therapy: Wound Vac . A review of R8's care plan for the focus area I am at risk for impaired skin integrity r/t [related to] impaired mobility, muscle weakness, paraplegia . revealed the goal for the planned care, initiated on 8/05/2022, was to minimize my risk for skin breakdown through the review dated. Interventions included I have a [name brand pressure reducing air mattress] to my bed. Date Initiated 8/19/2022 . Device check (air mattress) every 4 hours to ensure my air mattress is turned on and functioning properly to reduce the risk of skin breakdown. Date initiated: 01/17/2023 . Device Check: ensure air mattress is inflated and functioning properly during interactions/cares. Date Initiated: 1/19/2023. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/04/2023 at 11:58 a.m., R8 reported waking up one day to find his air mattress deflated and himself lying directly on the bedframe. R8 stated his air mattress must have been turned off by mistake at some time while he was sleeping. R8 did not remember the date the event occurred but was told he developed a new wound on his right buttock from lying on the bedframe. R8 reported due to his paraplegia, he did not have feeling in his lower body therefore did not realize the bed deflated. During an interview on 4/05/2023 at 8:32 a.m., LPN J reported being responsible for wound care prior to LPN K. LPN J confirmed R8 was found lying directly on his bedframe one morning after his air mattress was accidentally turned off. LPN J reported she was unsure of the date the event occurred. LPN J stated after the incident R8 was assessed to have a new DTI to the right buttock. LPN J confirmed the wound developed into a Stage 4 ulcer and now required treatment with wound Vac therapy. A review of the facility policy titled Skin and Pressure Injury Risk Assessment and Prevention, last reviewed 7/2021, revealed the following, in part: Interventions for Prevention and to Promote Healing: After completing a thorough assessment, evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management o pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessments (e.g., moisture management, impaired mobility .). Evidence-based interventions for prevention will be implement for all resident who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: . Provide appropriate, pressure-redistributing, support surfaces .

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to ensure appropriate follow-up for the use of an indwelling, urinary catheter for one Resident (R41) of two residents reviewed for catheter care. This deficient practice resulted in harm when R41 obtained a urethral tear [pressure ulcer through the urethra and surrounding tissue]. Findings include: R41 was admitted to the facility on [DATE] with diagnoses including diabetes, peripheral vascular disease, and heart failure. A review of R41's most recent quarterly Minimum Data Set (MDS) assessment, dated 2/03/2023, revealed he required extensive, one-person physical assistance with bed mobility, toilet use [including catheter management] and personal hygiene. The MDS Section H - Bladder & Bowel, revealed R41 had an indwelling, urinary catheter in place. Further review of Section H - Bladder & Bowel, revealed the following: Has a trial of a toileting program been attempted on admission/reentry or since urinary incontinence was noted in this facility? 0. No. Further review of the MDS assessment revealed R41 scored 14 out of 15 on the Brief Interview for Mental Status [BIMS], indication he was cognitively intact. A review of R41's Section H - Bladder & Bowel, of admission MDS assessment, dated 8/03/2023, revealed he did not have an indwelling, urinary catheter at the time of admission and was always continent of urine. An observation on 4/03/2023 at 3:19 p.m., revealed R41 sitting in bed. Urinary catheter tubing was observed to be leading from R41's right pant leg to a dependent drainage bag clipped to R41's right lower bedframe. At the time of the observation, R41 lifted his left pant leg to reveal a catheter securing device adhered to his right upper thigh. At the time of the observation, R41 reported the catheter was placed during a hospitalization and he was unsure of the reason. R41 reported having pain at the catheter insertion site and stated he believed he developed a sore at the tip of his penis. An observation on 4/04/2023 at 11:28 a.m., with Licensed Practical Nurse [LPN] K, revealed an indwelling, urinary catheter pulled toward R41's right leg leading from his penis to the catheter securing device attached to his right upper thigh. Further observation revealed a tear from R41's urethral meatus [opening at tip of penis where urine leaves the body] down though the right center of R41's ventral glans [underside of head of penis]. It was noted the tear was completely through the glans, stopping at this penile shaft. There was a white, purulent substance present in the wound and on the superior portion of the catheter tubing at the urethral entry point. LPN K reported a culture of the drainage was sent to the laboratory for analysis to rule out infection. LPN K was unsure how long the catheter was in place or what the indications for use of the catheter were. At the time of the observation, R41 complained of pain at the tip of his penis. R41 was unable to rate his pain on a scale of 1-10 but was observed wincing when reporting the pain. A review of R41's electronic medical record [EMR] from December 2022 through 4/03/2023, revealed no order for the catheter use or for care of the catheter, other than urine output monitoring. R41's EMR contained no documented daily catheter care or nursing assessments of the catheter site were included with R41's point of care documentation, assessments, progress notes, Medication Administration Records [MARs] and Treatment Administration Records [TARs] for December 2022 through April 2023. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Further review of R41's EMR revealed the following: 4/03/2023 at 4:21 p.m. - Situation: The change in condition/s reported on this CIC Evaluation are/were: Skin wound or ulcer . was performing wound care after being alerted to the fact that resident has had smelly drainage from the head of his penis, after this nurse confirmed information though assessment there was a call to his PHCP [primary physician] about the decision to start him on ABS [antibiotics]. A review of R41's hospital Discharge Summary - Detailed, dated 12/09/2022, revealed R41 was hospitalized from 11/30/2022 for treatment of pneumonia with a discharge date of [DATE]. Further review of the Discharge Summary -Detailed, revealed the following, in part: he did develop acute scrotal pain. Urology was consulted. He had catheter replace [sic] with removal of 1500cc [sic] [1500 milliliters of urine]. Recommended [brand name, indwelling, urinary catheter] remain in place at discharge with outpatient Urology follow-up . Follow-up: Of note, he is discharged with [indwelling, urinary] catheter in place and this is to remain in place until outpatient urology follow-up. Further review of R41's EMR from December 2022 through April 3, 2023, revealed no record of outpatient follow-up with urology as recommended in R41's hospital Discharge Summary - Detailed. A review of R41's physician progress noted, dated A review of R41's most recent physician progress notes, dated 2/08/2023 and 2/22/2023 revealed no assessment, diagnosis, or indication for continue use of the indwelling, urinary catheter. During an interview on 4/4/2023, at 11:35 a.m., the Director of Nursing (DON) confirmed there was no order for maintenance of R41's indwelling, urinary catheter. The DON acknowledged there were no documented indications for use of the indwelling catheter after R41's return to the facility following hospitalization on [DATE]. When asked why R41 did not follow-up with urology per the hospital discharge summary, the DON reported she was unsure. The DON stated the facility was undergoing many staffing changes in December 2022 and R41's follow-up appointment with urology was never scheduled and R41 was not trialed on a toileting program to assess if the catheter was still indicated following hospitalization . A review of the facility policy titled Incontinence, provided by the DON and last reviewed 12/2020, revealed the following, in part: Residents that enter the facility with an indwelling catheter, or receives one while in the facility, will be assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization is necessary.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to provide oxygen services per standards of practice for five Resident (#14, #15, #20, #28 and #33) out of five residents reviewed for oxygen services. This deficient practice resulted in the potential for the development of respiratory infections. Findings include: Resident #15 Resident #15 was admitted to the facility on [DATE] and had medical diagnoses including: chronic obstructive pulmonary disease (COPD), anxiety, kidney disease, and depression. A review of the most recent, complete Minimal Data Set (MDS) assessment for Resident #15, dated 1/5/23, revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #15 was cognitively intact. On 4/2/23 at 12:29 PM, an observation was made of Resident #15's room. Resident #15 had a wheelchair with an oxygen tank on the back and oxygen tubing connected to the tank with the oxygen tubing draped over the back of the wheelchair and touching the floor. The floor of Resident #15's room had a used tissue, a spoon, and used medication cup. On Resident #15's desk in the right corner of her room there was oxygen tubing opened sitting on top of the desk and not in a bag with several items on top of the desk next to the tubing. Resident #15 was lying in her bed and eating lunch with oxygen tubing in her nares and the tubing was touching the floor and connected to an oxygen concentrator which was on and set to 2.5 liters. On 4/3/23 at 8:08 AM, an observation was made of Resident #15's room. Resident #15 again had a wheelchair with an oxygen tank on the back and oxygen tubing connected to the tank with the oxygen tubing draped over the back of the wheelchair and touching the floor. On 4/3/23 at 1:00 PM, an interview was conducted with Licensed Practical Nurse (LPN) I in Resident #15's room. LPN I was asked about Resident #15's oxygen equipment and if it was properly stored and replied, No. The oxygen tubing that is not being used should be stored in a bag and any extra tubing that is not being used should be thrown away. Resident #15 stated her tubing had been changed last night but it was the first time in two weeks. Review of Resident #15's Treatment Administration Record (TAR) dated 3/1/23 through 3/31/23, revealed Resident #15 did not receive the treatment ordered for replacing antimicrobial oxygen storage bag on 3/31/23 per physician orders. On 4/4/23 at 10:05 AM, an observation was made of Resident #15's room. Resident #15 had been out of her room during this observation as she was noted to be at an appointment. Resident #15's oxygen concentrator was running, and her oxygen tubing was draped on the top of her bedding. Resident #20 Resident #20 was admitted to the facility on [DATE] and had medical diagnoses including: COPD, muscle weakness, anxiety, depression, and diabetes mellitus. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #20's physician orders, revealed an order for oxygen, start date 5/19/21, read in part, O2 [oxygen] at 2.5 L/Min [liters per minute] via nasal cannula continuous . A physician order for nebulizer as needed, start date 12/18/19, read in part, After completion of nebulizer. Rinse with fresh tap water, dry on clean paper towel .Store in plastic bag marked with name and date in between usage. Another physician order for nebulizer solution, start date 12/30/22, read in part, Ipratropium-albuterol solution 0.5-2.5 (3) MG[milligrams]/3ML[milliliters] 1 vial inhale orally every 2 hours as needed . Review of Resident #20's Medication Administration Record (MAR), dated 4/1/23 through 4/30/23, revealed that Resident #20 used his as needed nebulizer solution on 4/2/23 at 7:58 AM, 4/3/23 at 1:27 PM, and on 4/4/23 at 4:01 PM. Resident #20's MAR for April 2023 also revealed that his nebulizer was not rinsed after being used on 4/1/23 and 4/4/23. Review of Resident #20's care plan, date printed 4/4/23, read in part, I have oxygen therapy r/t [related to] dx [diagnosis] of COPD and acute/chronic respiratory failure. Administer oxygen via nasal cannula at 2.5 L/min continuously. Change/clean Nebulizer Equipment tubing, filters and mouthpiece per facility protocol. Change/Clean O2 equipment tubing, filters, bags, nasal cannulas, and masks per facility policy. On 4/2/23 at 12:02 PM, an observation was made of Resident #20 lying in his bed, in his room, resting with a sheet on. Resident #20 had a wheelchair next to a small bedside dresser with an oxygen tank on the back of the wheelchair, a pair of plaid pants on the seat of the wheelchair that were black and red with tiny white flakes on the pants and on the seat of the wheelchair, which appeared to be dried skin flakes. There was a nasal cannula attached to the oxygen tank and the nasal cannula was draped over the back of the wheelchair and onto the seat. On top of the small dresser was a nebulizer machine connected to tubing, and all the nebulizer attachments together with visible condensation in the medication cup. On top of the small dresser was also a cup of chewing tobacco spit and used chewing tobacco. Resident #20 also had an oxygen concentrator in the left corner of his room and it was set at 3.5 liters in which he was receiving oxygen therapy via nasal cannula. On 4/3/23 at 8:10 AM, an observation was made of Resident #20's room. Resident #20's wheelchair was next to a small bedside dresser, and the oxygen tubing was connected to a tank on the back of the wheelchair and draped over the back of the wheelchair on to the seat of the wheelchair not being utilized. Resident #20's nebulizer machine was on top of the small bedside dresser and connected to the nebulizer machine with visible condensation in the medication cup. Resident #28 Resident #28 was admitted to the facility on [DATE] and had medical diagnoses including: hypertension (elevated blood pressure), hyperlipidemia (elevated cholesterol), and diabetes mellitus. On 4/3/23 at 8:09 AM, an observation was made of Resident #28 in his room lying in his bed. Resident #28 had an oxygen concentrator next to the left side of his bed which was off, and the nasal cannula was connected to the oxygen concentrator and the nasal cannula was lying on the floor. On 4/3/23 at 1:00 PM, an interview was conducted with LPN I. LPN I was asked if Resident #28's oxygen equipment was properly stored and replied, No. The tubing on the concentrator should be stored in a bag because it is not currently being used. (continued on next page)

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	235349	A. Building B. Wing	04/05/2023

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/23 at 7:40 AM, an observation was made of Resident #28 in his room. Resident #28 was sitting up in his wheelchair, his oxygen concentrator was on and his oxygen nasal cannula was lying on the floor. The facility policy Oxygen Administration and Concentrator, dated 12/2020, read in part, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency .2. Staff shall document the initial and ongoing assessment of the resident's condition .4. Infection control measures include: b. change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated and document in the electronic health record . The facility policy Nebulizer Therapy, dated 01/2022, read in part, Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered as directed using proper technique and standard precautions .Care of the Equipment. 1. Disassemble parts after every treatment. 2. Store dry nebulizers mesh bags, clear plastic bag or proper clean storage per facility's preference . 41978 R33 R33 was admitted on [DATE] and had diagnoses including COPD, heart failure and diabetes. A review of R33's MDS assessment, dated 3/04/2023, revealed R33 scored 15 out of 15 on the BIMS, indicating she was cognitively intact. An observation on 4/04/2023 at 4:32 p.m., revealed R33 sitting in bed wearing a nasal cannula (device used to deliver supplemental oxygen through prongs placed in the nostrils) and tubing leading to a portable oxygen concentrator set to deliver three liters of oxygen per minute (3L/min). R33 reported she had COPD and required continuous supplemental oxygen use. Further observation revealed an inhaler containing albuterol sulfate 108 mcg (microgram) solution, lying on a bedside table directly to the right of the resident's bed. The inhaler was observed have 31 doses remaining of the original 200 doses per the inhaler packaging. R33 reported self-administering the medication daily when she felt short of breath. R33 stated staff were aware of her use of the medication. A review of R33's EMR revealed the most recent documentation of the measurement of her oxygen saturation [O2 sat, non-invasive measurement indicating how much oxygen is being carried by the blood, indication of efficient oxygen delivery] was 10/22/2022. During a review of R33's EMR, on 4/04/2022 at 4:25 p.m., LPN V confirmed the most recent measurement of R33's O2 sats were on 10/22/2022. LPN V reported R33 would have had respiratory assessments completed during a facility covid-19 outbreak in January 2023. LPN V stated she would check with the DON and report back to this Surveyor. On 4/05/2022 at 7:41 a.m., the DON reported there were no respiratory assessments available for R33 after 10/22/2022. The DON stated as a standard of practice residents on supplemental oxygen should have vital signs, including O2 sats, recorded daily. The DON confirmed the possibility of unidentified changes in condition when respiratory assessments are not completed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40383 Resident #14 A review of the medical records for R14 included diagnoses of hypertension, acute and chronic respiratory failure, congestive heart disease, diabetes, and COPD. Physician orders included May use O2 as needed to maintain oxygen saturation >= (greater than or equal to) 89%. Start date: 3/4/23 Status: Active. There was an additional conflicting order of May use O2 as needed to maintain oxygen saturation >= 92%. Start date: 2/22/22 Status: Active. Both O2 orders were different but both were active and neither order indicated an end date. The medical record also included a Care Plan which read in part: I have altered respiratory status/Difficulty Breathing acute and chronic respiratory failure, copd. Date Initiated: 04/27/2022. On 4/02/23 at 1:36 PM, an O2 concentrator was observed in R14's room. R14 was not wearing O2, and the tubing was observed lying on the floor. On 4/03/23 at 8:43 AM, R14 was in his room and was not wearing oxygen. The O2 concentrator was observed to be on, and the tubing was lying on the floor. On 4/03/23 at 6:20 PM, R14's O2 tubing was observed lying on the resident's bed and was not in a protective bag. During an interview on 4/03/23 at 6:24PM, LPN V observed the O2 on R14's bed and stated, The (O2) tubing should be in a bag when not in use. LPN V than exited the room with the Surveyor and left the O2 tubing on the bed. On 4/04/23 at approximately 10:30 AM, R14's O2 tubing was observed lying on the resident's bed and was not in a protective bag.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 This citation pertains to intake # 00133956 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety as evidenced by: 1. Failing to ensure hot water was supplied to the kitchen for hand washing and dish washing. 2. Failing to properly sanitize food contact surfaces in the three compartment sink. 3. Failing to properly sanitize carts used to transport food trays to resident halls. 4. Failing to hold hot food on the serving line above 135 F 5. Failing to dispose of expired food. 6. Failing to remove dented cans from the in-use shelves in the dry storage room. 7. Failing to repair/replace flooring and deteriorated walls which were inundated with water. 8. Failing to maintain and handle (cooling and reheating) potentially hazardous food, delivered to one Resident (#8), in a safe manner to prevent food borne illness. These deficient practices have the potential to result in food borne illness among any and all 44 residents of the facility. Findings include: 1. On [DATE] at 11:15 AM during the initial tour and each subsequent visit to the kitchen, it was observed that hot water was not being supplied to the dish machine or hand sinks. The water temperature in the low temperature dish machine was measured to be between 72 F and 95 F. This same condition was observed at the two hand sinks used by kitchen staff. A review of the data plate on the mechanical dish washer was conducted, and it stated the minimum water temperature for its operation was 120 F. On [DATE] at 12:30 PM interviews with (resigned) Dietary manager A and kitchen staff (KS) B, D and E were conducted and all stated the kitchen had lacked adequate hot water for dish washing and handwashing for three months. DM A stated staff were boiling water on the stove to place in the three compartment sink for washing some pots and pans. The FDA Food Code 2017 states: ,d+[DATE].12 Handwashing Sink, Installation. (A) A HANDWASHING SINK shall be equipped to provide water at a temperature of at least 38 C (100 F) through a mixing valve or combination faucet ,d+[DATE].15 Warewashing Machines, Manufacturers' Operating Instructions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions. 2. On [DATE] at 11:45 AM, it was observed the three compartment sink was being used to wash, rinse and sanitize food contact surfaces, included pot, pans, serving utensils and cutting boards. Cook B was requested to demonstrate the testing procedure for the sanitizing solution. Cook B measured the temperature of the solution and reported it as 82 F. A section of QT 40 Quaternary test strip was removed and placed in the solution. A zero 0 ppm (parts per million) concentration of Quat was reported. A second test was conducted and had the same result. Cook B stated the dispenser had not been working correctly for a few days but the vendor had not come in to service it. On [DATE] at approximately 9:30 AM, Cook E was observed to be conducting dish washing duties at the three compartment sink. Cook E was observed to place pans into the sanitizing solution and removed them within 15 seconds. The concentration of the Quat was measured using the facility's QT 40 test strips and determined to be less than 100 ppm. A review of the container of concentration quat required a minimum of 60 seconds immersion of food contact surfaces in a solution containing a minimum of 150 ppm quat. The FDA Food Code 2017 states: ,d+[DATE].114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ,d+[DATE].11(C) shall meet the criteria specified under S,d+[DATE].11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (C) A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24 C (75 F), (2) Have a concentration as specified under S ,d+[DATE].11 and as indicated by the manufacturer's use directions included in the labeling, and (3) Be used only in water with 500 MG/L hardness or less or in water having a hardness no greater than specified by the EPA-registered label use instructions; 3. On [DATE] at approximately 1:35 PM KS E was observed cleaning the upright wheeled metal carts used to transport food trays to residents in their rooms. KS E was using a bucket with a solution and a cloth dipped in the solution. When asked what the solution was, KSE stated I get it from over there. KS E explained the bucket was filled with quat solution from the dispenser used to fill the sanitizing compartment of the three compartment sink. The solution in the bucket was tested for Quat concentration and found to be between 0 and 100 ppm. A review of the container of concentrated Quat revealed the concentration of the mixed solution was to be between 150 ppm and 400 ppm for food contact surfaces. The FDA Food Code 2017 states: ,d+[DATE].114 Manual and Mechanical Warewashing Equipment, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Chemical Sanitization - Temperature, pH, Concentration, and Hardness. A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under ,d+[DATE].11(C) shall meet the criteria specified under S,d+[DATE].11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, P and shall be used as follows: (C) A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24 C (75 F), (2) Have a concentration as specified under S ,d+[DATE].11 and as indicated by the manufacturer's use directions included in the labeling, and (3) Be used only in water with 500 MG/L hardness or less or in water having a hardness no greater than specified by the EPA-registered label use instructions 4. On [DATE] at approximately 7:30 AM, observations were made of the morning meal service and included measuring temperatures of hot food on the steam table. A container, identified by Cook E as pureed bread, was measured with a super fast metal stem Thermapen food thermometer, and found to be 118 F. At 12:05 PM during observations of the noon meal, the temperature of the pureed vegetable was measured and observed to be 121 F. An interview with Cook E was conducted at this time who stated she had measured the product to be 168 F. When asked if she had pushed her thermometer all the way to the bottom of the pan, sitting in the steam table, Cook E responded Yes. I probably did. The FDA Food Code 2017 states: ,d+[DATE].16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S,d+[DATE].19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in , d+[DATE].11(B) or reheated as specified in ,d+[DATE].11(E) may be held at a temperature of 54 C (130 F) or above; 5. On [DATE] at approximately 11:40 AM, a container of cottage cheese was observed in the walk in cooler. The container had a manufacturer's expiration date of [DATE]. Written on the top of the container was: open date: [DATE] Use by: [DATE]. On [DATE] at approximately 9:35 AM, the refrigerator in the nourishment room behind the nurses' station for the ,d+[DATE] hall was observed to have 15 cartons of ,d+[DATE] pint milk with expiration dates of [DATE] and [DATE]. The FDA Food Code 2017 states: ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO -EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. 6. On [DATE] at approximately 1:30 PM, the dry storage room, storing canned goods, was observed. Three #10 cans of food (2 pumpkin, 1 pears) were observed to have substantial dents, impacting the seams and/or the upper lid seals. On [DATE] at approximately 9:15 AM, these cans were brought to the attention of Registered Dietitian F who acknowledged the cans should not be on the shelves and should be removed for disposal. The FDA Food Code 2017 states: ,d+[DATE].15 Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants. 7. On [DATE] at approximately 11:35 AM, the floor in front and under the dish machine was observed. This floor was a red [NAME] tile, and directly in front of the garbage disposal/overhead sprayer, the tiles were loose and the flooring below was inundated with water. When pressure was put on the tiles, water was forced up through the grout lines confirming the inundation of subsurface water saturation and inadequate sealing of the floor tiles. At this same time the wall area under the dish machine and flanking drain boards was observed to be in poor condition. The drywall was pitted, stained and the baseboard molding had peeled away from the wall. The FDA Food Code 2017 states: ,d+[DATE].11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. 41978 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. On [DATE] at 12:45 p.m., a bedside table holding a meal tray was observed to be positioned on the left side of Resident #8's bed. Resident #8 was observed lying in bed with the meal tray within reach. The meal tray was observed to contain an empty plate, two empty plastic coffee mugs and an empty milk container with a straw. Resident #8 reported the meal tray on the bedside table was from the previous evening's dinner meal which he finished eating earlier the current morning. Further observation revealed a second meal tray at the end of the Resident's bed atop a dresser. Resident #8 reported the tray on the dresser was the current day's breakfast tray, which he had not yet eaten. The meal tray on the dresser contained a cheese omelet and one English muffin, one covered coffee cup and unopened carton of milk. At the time of the observation, and unidentified Certified Nurse Aide (CNA) entered the room and removed the empty meal tray from the bedside table to the left of the Resident's bed. Resident #8 asked the CNA to move the second meal tray from atop the dresser to the bedside stand for him to eat. The CNA proceeded to move the second meal tray from the Resident's dresser to the bedside table next to the Resident in bed. A third meal tray, containing a covered plate, one covered juice glass containing a red liquid and an unopened milk carton, was observed to be atop another bedside table to the right of the Resident's bed. Resident #8 reported the third meal tray was the current day lunch tray. Resident #8 reported he was not always hungry at scheduled mealtimes so staff would leave the trays for him to eat at his leisure. Resident #8 added it's ok, I have not been sick from it. On [DATE] at 11:31 a.m., Resident #8 was observed lying in bed with a meal tray on a bedside table directly to the left, and within reach, of the Resident. The meal tray was observed to contain an uneaten, cheese omelet with temperature of 74 degrees Fahrenheit, as measured using a surface infrared thermometer, and one English muffin. A second meal tray was observed atop the Resident's dresser. Further observation revealed the second meal tray contained a small, covered bowl of cottage cheese dated [DATE] with a UB (use by) date of [DATE], a plate containing a serving of mashed potatoes and brown gravy, diced carrots and a bowl of what appeared to be chicken and dumplings. Infrared temperature measurements of the food on the second meal tray were as follows: cottage cheese 71 degrees Fahrenheit, mashed potatoes, gravy, and diced carrots 70 degrees Fahrenheit and the chicken and dumplings were at 74 degrees Fahrenheit. Resident #8 again stated he was not hungry when the meals were brought to his room and staff left the trays for him to eat at his leisure. The FDA Food Code states: ,d+[DATE].11 Safe, Unadulterated, and Honestly Presented. FOOD shall be safe, unADULTERATED, and, as specified under S ,d+[DATE].12, honestly presented. and ,d+[DATE].11 Reheating for Hot Holding. (A) Except as specified under (B) and (C) and in (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C (165 F) for 15 seconds. ,d+[DATE].14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 13791 Based on observation and interview, the facility failed to dispose of garbage and refuse properly, as evidenced by overflowing outdoor refuse containers, including bags of garbage and refuse on the ground between containers. This deficient practice has the potential to result in insect and rodent infestations, as well as an attractant for larger wild and domestic animals creating an unsafe environment for residents, staff and visitors. Findings include: On 4/02/23 at 11:15 AM during the initial entrance into the facility, two large (6 yard) metal garbage containers were observed on the north end of the parking lot. The containers were observed to be overflowing with bags of garbage and refuse, with two bags observed on the ground between containers. On 4/03/23 at approximately 11:15 AM, an interview was conducted with the Maintenance Supervisor (MS) C concerning the overflowing garbage containers. MS C stated the containers are large enough to hold three days worth of garbage/refuse, but staff do not push the bags back into the containers to properly utilize the volume provided. MS C further stated this issue had been discussed with staff in dietary, nursing and environmental services in the past but continues to be a problem.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40383 Based on observation, interview, and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that included development, monitoring, and evaluation of performance indicators, identification of quality issues, and the conducting of distinct performance improvement projects to correct quality deficiencies and maintain sustained compliance. This failure had the potential to affect all 44 residents in the facility. Findings include: On 4/03/23 at 12:20 PM, the QAPI plan and sign in sheets were requested for the past 12 months. Only one QAPI meeting with the required committee members from 2023 was presented and no meetings from 2022 were presented. On 4/03/23 at 5:11 PM, the Nursing Home Administrator (NHA) stated he may not be able to find the meeting minutes or previous QAPI committee work as there had been a change in leadership. He indicated there was nothing in the computer on past meetings. He said he was now shooting for monthly QAPI meetings. The QAPI plan was reviewed and discussed with the NHA who agreed that not all the elements of the QAPI policy were currently in place such as quality action plans and process improvement plans. The NHA stated he was unable to find any quality plans from the past year. The NHA said, I am starting from scratch . They do not call me in until it is bad. A review of a facility policy titled, Quality Assurance and Performance Improvement read in part, .Develop and implement appropriate plans of action to correct identified quality deficiencies . Regularly review and analyze data . and act on available data to make improvements .

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40383 Based on interview and record review, the facility failed to ensure that the Quality Assurance and Performance Improvement (QAPI) committee met at least quarterly with the required committee members. This deficient practice resulted in the potential for ineffective coordination of medical care and delayed resolution of facility issues, placing all 44 residents in the facility at risk for quality care concerns. Findings include: On 4/03/23 at 12:20 PM, the QAPI plan and sign in sheets were requested for the past 12 months. Only 3 QAPI meeting sign in sheets from 2023 were presented. On 4/03/23 at 5:11 PM, the Nursing Home Administrator (NHA) stated he may not be able to find the meeting minutes or sign in sheets as there had been a change in leadership. The QAPI sign in sheets for 2/22/23 were observed to have the required members present. The QAPI sign in sheets for 3/3/23 indicated the Director of Nursing (DON) and the Medical Director were not present. The QAPI sign in sheet for 3/29/23 indicated the DON and Infection Preventionist were not present. No other evidence of quality assurance planning or meetings were presented for the past 12 months. The facility policy Quality Assurance and Performance Improvement dated as last reviewed 10/2022 read in part: The QA (Quality Assurance) Committee shall be interdisciplinary and shall: Consist at a minimum of: director of nursing services; The Medical Director or his/her designee; At least three other members of the facility's staff, at least one of which must be the administrator, owner, a board member or other individual in a leadership role; and The infection control and prevention officer. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 This citation has two separate deficient practice statements (DPS) DPS A: Based on interview, and record review, the facility failed to maintain monthly mapping and line listing, track infections in real time, monthly summaries, and complete contact tracing for Covid-19 outbreak for employees. This deficient practice had the potential for infections to be ineffectively tracked and traced and the potential for further infection to spread to other residents. Findings include: On 4/2/23 at approximately 11:30 AM, the Survey team entered the facility, and a request was made for Covid-19 policies and procedures along with information regarding which facility staff member oversaw infection control prevention measures. On 4/3/23 at approximately 2:00 PM, the Director of Nursing (DON) was interviewed and asked if the staff member who oversaw infection control prevention was available. The DON stated Licensed Practical Nurse (LPN) J [acting Infection Control Preventionist] was unavailable and she would be covering as the key personnel overseeing the implementation of the program. On 4/3/23 at 3:00 PM, the facility infection control binder was reviewed, dated January 2023 to the current date. Infection control binder was reviewed for infections line listing, infections mapping, and infections summary for the months of January, February, March, and April. The infection control binder was found to lack a monthly infection summary for February and March 2023, lacked the start of an infection line listing or mapping for April 2023 and was blank (without known infections for carry over from March and newly acquired infections for April 2023). On 4/4/23 at 10:50 AM, an interview was conducted with LPN G [former Infection Control Preventionist] regarding infection control practices. LPN G stated that the March 2023 infection watch had not been started and she had completed some of those yesterday. LPN G was asked how many infection watches she did. She listed the names of four residents. LPN G was asked if she had started one for Resident #41 who had a urinary tract infection and replied, No. I was not aware of that infection. On 4/4/23 at 11:30 AM, during a continued interview with LPN G regarding the Covid-19 outbreak within the facility during February and March 2023 and the line listing and mapping for infection control. LPN G stated, there was a focus infection control survey completed in June 2022. LPN G and Surveyor went over the line listing and mapping for infection control for July 2022 to current date. The infection control binder was then reviewed by both LPN G and this Surveyor and was found to be lacking in the March 2023 line listing; one carry over infection from February into March and one infection not listed on the mapping and indicated on the line list from room [ROOM NUMBER]. LPN G was asked when she was responsible for infection control how she did her tracking and responded, In real time. If an infection was new, I added it to the line list and mapping right away and started an infection watch. LPN G was asked if there was any reason that the April 2023 line list and mapping was blank and replied, It should not be. There should be carry over infections listed, and new infections added as they arise and mapping to. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/4/23 at approximately 12:00 PM, LPN G was asked about contact tracing during the Covid-19 outbreak and responded, I initially did contact tracing in February until I ended up with Covid-19 on March 2nd, 2023. There is no contact tracing that I can see for the month of March 2023. I guess no one continued to do contact tracing. LPN G was asked about the monthly summary for February 2023 and replied, When I came in yesterday, I noticed it had not been done and I completed it yesterday. The summary must be in the office, but it should be in the binder. LPN G further stated, the monthly summary is usually started the third week of the month for our quality assurance meeting and then if more infections occur, they are added to the summary. On 4/4/23 at 4:58 PM, an interview was conducted with the DON. The DON was asked which facility staff was responsible for overseeing infection control and replied, I oversee the staff in charge of infection control. The DON was asked if she knew if there was any contact tracing completed for the month of March 2023 during the Covid-19 outbreak and replied, I do not know. I do not see anything documented. The DON was asked if she was aware of how many current infections were active for the month of April 2023 and replied, There is one resident with a urinary tract infection [resident was named] and one with a respiratory infection and I am not sure who that is exactly. I believe those are the only two. The DON was made aware that there were five current infections active and five carry over infections from March 2023 for the month of April 2023. The DON was asked if the infection line listing and mapping was started for the month of April 2023 and replied, I doubt it was started. The DON looked at the infection control binder for the month of April 2023 and confirmed that it was blank and had not been started. The DON was asked what her expectation would be to track infections in the facility and replied, I would expect infection to be tracked in real time. The facility policy Infection Prevention and Control Program, dated 02/2023, read in part, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases . Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases .3. Surveillance: b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings to the facility's Quality Assessment and Assurance Committee .6. Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. b. Antibiotic use protocols ns system to monitor antibiotic use will be implemented as a part of the antibiotic stewardship program. c. The Infection Preventionist serves as the leader of the antibiotic stewardship program . The facility policy Coronavirus Surveillance, dated 09/2022, read in part, Policy: This facility will implement heightened surveillance activities for coronavirus illness during periods of transmission in the community . Policy Explanation and Compliance Guidelines: .8. The Infection Preventionist, or designee, will monitor the following information: .a. The number of residents and staff who have fever, respiratory signs/symptoms, or other signs/symptoms related to Covid-19. b. The number residents and staff who have been diagnosed with Covid-19 and when the first case was confirmed . 13791 DPS B: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to develop a comprehensive Water Management Plan (WMP) to address the control and spread of Legionella bacteria in the facility water system, in accordance with QSO 17-30 Hospitals/CAHs/NH, Revised 7-6-2018. The facility failed to Develop and implement a water management program that considers the ASHRAE 188 (American Society of Heating, Refrigerating and Air-Conditioning Engineers) and the CDC (Centers for Disease Control) tool kit. The failure to develop a comprehensive Water Management Plan has the potential for the proliferation and transmission of Legionella in the circulating water of the building and the spread of Legionella infections in all 70 residents. Findings include: On 4/3/23 a review of the facility's Legionella WATER MANAGEMENT PROGRAM (dated 11/2017)(Revised Date 12/2020) document was conducted. These documents were presented in its entirety as the facility's WMP for Legionella control. This document did not contain any specific parameter related to a water management plan for the facility, rather, was a blank template of what a WMP should contain. On 4/4/23 at approximately 9:30 AM an interview was conducted the the interim nursing home administrator (INHA) concerning the lacking information in the document provided as the WMP. INHA stated the issue would be researched and if additional information were located, would be transmitted electronically for review. On 4/4/23 at 5:30 AM, an electronically transmitted document sent by the INHA was reviewed. This electronically transmitted document was a blank template of a WMP, similar to the first provided as a paper document. A signature/review sheet titled Water Management Program was reviewed. This document, initially dated 2/15/22 by a previous NHA indicated initial approval of the WMP. Below this signature line, Reviewed/Revised provided for documentation of the review of the document. The first line, dated 2/4/23 was signed by the current INHA. The Water Management Team (WMT) members were reviewed in the document, but contained the names of the previous NHA, Director of Nursing, Infection Preventionist, and Maintenance director, who no longer were employed at the facility and did not perform any duties associated with the WMP. Absent from the facility's WMP documents were: 1. Identification of a WMT comprised of current facility staff and others designated to assess and review the facility's water system for potential risks associated with water borne pathogens. 2. An assessment as to the locations of plumbing fixtures posing a risk for harborage and/or transmission of Legionella bacteria. 3. Specific Control measures at specific locations for the elimination/control of Legionella. 4. Specific measurable Critical limits within the control measures of areas within the building. 5. Defined monitoring of parameters, which were identified as control measures and their associated limits, to determine targeted interventions were present. 6. Documentation of any monitoring. 7. Review of data from defined monitoring documented to demonstrate interventions were either functional or requiring to be refined. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/4/23 at approximately 10:30 AM, an interview with the Nursing Home Administrator (NHA) was conducted to review the WMP. The NHA acknowledged the above components could not be located, no data collection had been located, and no review of data to determine the efficacy of the entire Water Management program implementation.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 45123 Based on interview, and record review the facility failed to track, and maintain the Covid-19 vaccination status documentation for facility staff and contracted staff. This deficient practice had the potential unvaccinated staff to provide direct care and/or come into close contact with residents who are at high risk for complications regardless of vaccination status. Findings include: On 4/2/23 at approximately 11:30 AM, the Survey team entered the facility, and a request was made for the staff vaccination matrix information for both facility and contracted staff. On 4/3/23 at approximately 1:30 PM, the infection control policies, employee list, contracted staff list, and other Covid-19 vaccination materials were reviewed. A review of the contracted and facility staff vaccination matrix revealed the following: blank columns where vaccination information should be recorded and missing staff roster names. On 4/3/23 at approximately 2:00 PM, the Director of Nursing (DON) was interviewed and asked if the staff member who oversaw infection control prevention was available. The DON stated Licensed Practical Nurse (LPN) J [acting Infection Control Preventionist] was unavailable and she would be covering as the key personnel overseeing the implementation of the program. On 4/4/23 at 11:30 AM, during an interview regarding a COVID-19 outbreak in February and March 2023, the following information was discovered: LPN G [former Infection Control Preventionist] stated she had not added any new employees to the staff vaccinations matrix since January 2022 and confirmed there had been several new hires and terminations during the period of February to March 2023. On 4/4/23 the originally provided facility staff Covid-19 vaccination matrix was compared with the current employee list. The following inaccuracies were found: a.) Lacked Covid-19 vaccination status for all therapy contracted staff, b.) Lacked Covid-19 vaccination status for 30 employees, c.) Total number of staff listed 81 and, d.) Lacked staff title. On 4/4/23 at 4:58 PM, an interview was conducted with the DON. The DON was asked if the staff Covid-19 vaccination tracking original list provided to the Survey team was accurate. The DON stated the list should be accurate and that it was obtained from corporate human resources. On 4/5/23 at approximately 8:00 AM a second and third staff Covid-19 vaccination matrix was provided to the Survey team. One matrix was identified with a date on the top of 1/4/2023 and a the other without a date and confirmed by the DON to be most current as of February 2023. Both documents were compared for accuracy and found to still contain incomplete vaccination statuses recorded. The following issues were identified: (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a.) Total number of staff listed on the 1/4/23 list = 70 compared to February 2023 = 66, b.) Former Nursing Home Administrator (NHA) was listed on the 1/4/23, c.) Former DON was listed on the 1/4/23, d.) Lacked Covid-19 vaccination status of the medical director, e.) Current NHA and DON lacked listing on the February 2023 matrix and, f.) Lacked contracted therapy staff on either matrix. Note: 74 employees listed on staffing sheet and 12 agency staff listed on a separate sheet as newly hired after 3/1/23. Neither matrix accounted for all current employees listed. Further review of the facility provided staff Covid-19 vaccination matrixes had the following concerns identified: a.) Lacked eight certified nurse aide agency staff, b.) Lacked four registered nurse agency staff and, c.) Lacked one housekeeping staff. The facility policy Employee Vaccinations, dated 01/2021, read in part, Policy: It is the practice of this facility to reduce the risk of HCP [Health Care Providers] transmitting vaccine-preventable diseases to residents and provide a service to the individual staff member. To ensure all HCP are up-to-date with recommended immunizations, staff's vaccination and immunity status will be reviewed at time of hire and on a regular basis, with consideration of offering needed vaccines, if necessary . The facility policy Covid-19 Reporting and Covid-19 Vaccine Reporting, dated 09/2022, read in part, Policy: It is the policy of this facility to share appropriate information regarding Covid-19 and Covid-19 vaccines with staff, residents and their representatives and to report Covid-19 information to the local/health department . Policy Explanation and Compliance Guidelines: 1. The facility has implemented a system of surveillance designed to identify possible communicable disease or infections, including Covid-19, before they can spread to other persons in the facility. For Covid-19, see Coronavirus Surveillance Policy . The facility policy Coronavirus Surveillance, dated 09/2022, read in part, Policy: This facility will implement heightened surveillance activities for coronavirus illness during periods of transmission in the community . Policy Explanation and Compliance Guidelines: .8. The Infection Preventionist, or designee, will monitor the following information: .d. staff and resident vaccination status .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 13791 This citation pertains to complaint intake: 133852 Based on observation, interview and record review, the facility failed to maintain the water heaters supplying hot water to the kitchen resulting in insufficient hot water for dishwashing and hand washing. This deficient practice has the potential to result in inadequate infection control measures, food service sanitation and other cleaning activities, affecting all 44 residents in the facility. Findings include: On 4/02/23 at 11:20 AM, the kitchen facility was visited. It was learned immediately the kitchen was not provided hot water to the mechanical dish machine, the two hand sinks or the three compartment sink. The water temperature at the hand sink adjacent to the dish machine was measured and found to be 85 F. While Kitchen Staff (KS) were operating the dish machine, the temperature of the wash and rinse water was measured to be between 78 F and 98 F. The dish machine's data plate stated the minimum operating temperature was 120 F. An interview with KS A revealed this condition of inadequate hot water began around the first of the year. KS A continued to explain that the facility would have a repair person in, the kitchen would have hot water for less than a week and then again have no hot water. KS A stated that over the last three months, there were more weeks the kitchen did not have hot water than weeks when it did have hot water. KS A stated the kitchen staff was frustrated that this condition had continued for as long as it had. On 4/02/23 at approximately 12:15 PM, the Interim Nursing Home Administrator (INHA) was requested to provide all historical information and correspondence related to the replacement of the failed water heater. At this same time an interview was conducted with INHA who stated the water heater had been repaired a number of times then failed following the repair. The INHA understood the urgency of the condition and stated he had been in contact with corporate level staff to make a payment to a selected contractor to effect the replacement. On 4/03/23 at approximately 8:00 AM, printed information related to the bid for services to replace the water heater from a local plumbing contractor was received and reviewed. The bid had been prepared and submitted by Contractor Service Coordinator (SC) U, and had been accepted by the INHA on 3/24/23. On 4/3/23 at approximately 8:45 AM, a telephone interview was conducted with SC U who explained the contractor was waiting for a deposit, as specified in the bid/contract document. SC U reiterated the contractor had not received the down payment and would not begin the replacement until the time this payment had been received, was defined as 50% of the project cost. On 4/3/23 at approximately 9:15 AM, an interview with INHA was conducted. INHA expressed frustration that the down payment had not been made to the plumbing contractor to get the project moving. The INHA provided email records documenting eight correspondence with corporate level staff, requesting that the money be sent immediately to the contractor. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/3/23 at approximately 10:30 AM, the State Agency was provided documentation and confirmation from SC U that a payment had been made and the installation of a new water heater was being scheduled.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 13791 Based on observation and interview, the facility failed to provide a safe, functional and sanitary environment for residents, staff and the public as evidenced by: 1. Failing to replace night lights in 9 resident rooms. 2. Failing to repair/replace a sink and sink base at a nurses' station. 3. Failing to replace floor tiles in the dining room which were curling and creating a trip hazard. This deficient practice has the potential to result in falls to ambulatory residents, staff and visitors due to the night lights and floor tiles, and result in unsanitary conditions at the hand sink for a nurses' station for two of four halls, which cannot be properly cleaned. Findings include: 1. On 4/2/23 between 1:00 PM and 3:00 PM, all resident rooms were observed to have wall recessed night lights which were not functioning. On 4/3/23 at approximately 9:00 AM, an interview with Maintenance Supervisor (MS) C was conducted and learned that none of the facility staff, including maintenance, administration or housekeeping were aware of how the night lights in resident rooms were activated. At approximately 1:15 PM, an interview was conducted with MS C who stated the previous maintenance supervisor was contacted and learned the resident room night lights were activated by a photo sensor located on the exterior of the building, and the lights were designed to come on when light levels dropped. On 4/4/23 between 6:50 AM and 7:30 AM, resident rooms were observed for functioning night lights. Approximately half of the resident room doors were closed due to cares being provided or residents sleeping and observations of the functioning of the night lights were not made. Of the approximately 24 resident rooms observed the following nine rooms were observed with night lights which were not functional: 105; 106; 202; 215; 308; 309; 316; 403; 409. On 4/4/23 at approximately 8:45 AM an interview was conducted with MS C who stated the facility had purchased three boxes of bulbs for the night lights and would be installed in all rooms which had been identified as having non-functional bulbs. 2. On 4/3/23 at approximately 10:15 AM, the sink and sink base behind the 100/400 hall nurses' station was observed to be in poor condition. The 4 inch plastic laminate on the rear back splash wall was peeling off, revealing the glue and fiber board. The doors to the cabinet below the sink were hanging loosely, the drawer was damaged. An interview at this time was conducted with Certified Nurse Aide N who stated the sink was gross, and often the drain emanated foul odors like sewer gas. Staff did not feel the sink was a sanitary place to wash their hands. 3. On 4/3/23 at approximately 2:30 PM, the floor in the main dining room was observed. An area in the center of the room, was tiled with a darker vinyl tile with many of them curling up and creating lips, bumps and edges which caught the bottoms and toes of persons shoes as they walked over them. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/4/23 at approximately 10:30 AM, while discussing the above issues with the Interim nursing home administrator (INHA), he stated he was aware of these issues and was trying to increase the priority of the repairs to the corporate staff responsible for providing the funding.