STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235633	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACON HILL AT EASTGATE	1845 BOSTON BLVD S E GRAND RAPIDS, MI 49506

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

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label, date, and store medications in 3 out of 4 medications carts, resulting in the potential for decreased efficacy of medications and the exacerbation of medical conditions. Findings include: Review of the facility policy Medication Storage last revised 3/29/20 revealed, It is the policy of this facility to ensure all medications housed on our premises will be stored in the nurse servers according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Review of the manufacturer guidelines for Assure Prism control solution last revised 2/16 revealed, Check the expiration dates printed on the bottle. When you first open a control solution bottle, record the discard date (date opened plus three (3) months) in the space provided on the label. Review of the manufacturer guidelines for Fluorometholone-Eye drops revealed, . only keep for four weeks once the bottle has been opened so throw away the bottle after this time, even if there is some solution left. This will help to prevent the risk of eye infections. Review of the manufacturers guidelines for [MEDICATION NAME] last revised December 2017 revealed, Throw away [MEDICATION NAME] when the counter reaches zero (0) or 3 months after you take [MEDICATION NAME] out of its foil pouch, whichever comes first. https://www.azpicentral.com/[MEDICATION NAME]/[MEDICATION NAME].pdf#page=1 Review of the The International Pharmacopoeia - Ninth Edition, 2019 revealed, Multidose ophthalmic drop preparations may be used for up to 4 weeks after the container is initially opened. http://apps.who.int/phint/2017/index.html#p/home During observations and interviews beginning on 9/9/20 at 9:59 A.M., the First Floor Medication Station, across from room [ROOM NUMBER], contained a bottle of Vitamin C 500mg with an expiration date of 5/2020, a bottle of multivitamin with minerals with an expiration date of 7/2020, a bottle of stool softener with an expiration date of 8/2020, a bottle of Assure Prism test strips with no discard date written on the bottle, a bottle of Flucrometholone 0.1% (eye drop) dated 7/4/20 (outside of the manufacturers guidelines), and 2 bottles of Refresh tears with no open date written on the bottles. The Second Floor Medication Station, across from room [ROOM NUMBER], contained a bottle of Assure Prism test strips with no discard date written on the bottle. The Second Floor Medication Station, across from room [ROOM NUMBER], contained a bottle of Assure Prism test strips with no discard date written on the bottle and a [MEDICATION NAME] ([MEDICATION NAME]) inhaler still attached to the spacer (long tube that attaches to the inhaler) with no open date or residents name/initials written on the inhaler or the spacer. Registered Nurse (RN) D reported that the medication expiration date should be assessed prior to administering medications to residents and expired medications should be discarded. RN D reported that open dates should be written on the bottles of medications. RN D verified that no open dates were written on the inhaler and reported that the open dates are written on the bag the inhalers are placed in.
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.** Based on observation, interview, and record review the facility failed to: 1. Prevent contamination of food stored in the walk-in cooler; 2. Store food product off of the floor; 3. Properly date mark and discard potentially hazardous foods; 4. Properly store items requiring refrigeration after opening; 5. Clean food contact surfaces to sight and touch, and; 6. Maintain general cleanliness of the kitchen. These conditions resulted in an increased risk for contaminated foods and an increased risk of food borne illness that affected 26 residents consuming food from the kitchen. Findings include: 1. During the initial tour of the kitchen starting at 9:10 AM on 9/9/20, with Cook K, it was observed that there was a leak in the walk-in cooler ceiling. When asked how long the leaking has been taking place, Cook K stated it had just started this weekend and was being fixed. At this time, it was observed that some of the rack space was cleared, but leaking water from the walk in cooler ceiling was dripping on a onion sitting on the storage rack. When shown this, Cook K took the onion and discarded it. During a revisit to the walk in cooler with Dietician J, at 9:33 AM on 9/9/20, it was observed that a box of cabbage was stored in a manner allowing dripping water from the ceiling onto the food product. According to the 2013 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 -3-306. 2. During the initial tour of the kitchen at 9:20 AM on 9/9/20, it was observed that six boxes of bread products were stored on the ground in the walk-in freezer. When asked if the kitchen received any deliveries today, Cook K stated, No deliveries today. When asked why food product was stored on the floor, Cook K stated, We don't have space. During a revisit to the walk-in units, with Dietician J at 9:33 AM on 9/9/20, it was observed the six boxes of food product were still stored on the floor, when asked about the floor storage Dietician J stated, they are usually stored off the floor on crates. According to the 2013 FDA Food Code section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: .(3) At least 15 cm (6 inches) above the floor . 3. During the initial tour of the kitchen starting at 9:10 AM on 9/9/20, an interview with Cook K found that the facility marks potentially hazardous food items for Six days once prepped or opened. At this time an open gallon of 2% milk was found, in the walk in cooler, with no discard date. At 9:25 AM on 9/9/20, observation of the cooks reach in cooler found, an open gallon of 2% milk with no discard date, two open packages of smoked ham with no discard date, two open packages of honey ham with no discard date, and a large gallon bag of corn beef hash with no discard date. Cook K discarded all items at this time. Review of the salad cooler at 9:35 AM on 9/9/20, with Dietician J, found an open bag of brown tinged lettuce with no discard date, once shown to Dietician J she stated, Throw it out. Further observation of the salad cooler found a container of cooked bacon dated 9-4 to 9-6, a container of banana cake dated 9-1 to 9-7, and an open half gallon of chocolate milk with no discard date. According to the 2013 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) .FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5C (41F) or less for a maximum of 7 days . According to the 2013 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is appropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). 4. During the initial tour of the kitchen at 9:30 AM on 9/9/20, it was observed that two, half empty,

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

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

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) gallon containers of BBQ sauce and an open bottle of low sodium soy sauce, were observed stored under the preparation table across from the cook line. Each container stated to Refrigerate After Opening. Cook K discarded all three bottles at this time. According to the 2013 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) .FOOD shall be maintained: (1) At 57C (135F) or above .(2) At 5C (41F) or less . 5. During the initial tour of the kitchen at 9:54 AM on 9/9/20, a review of the clean utensil drawers found a yellow mechanical scoop with dried stuck on debris in the scoop and food crumb accumulation in the middle and bottom clean utensil drawers. When asked how often these drawers should get cleaned, Dietary Aide M stated, Once a week. At this time, the can opener was found to have large dried on red splatter marks around the face and blade of the device. Observation of the pots and pan room with Dietician J at 9:57 AM on 9/9/20, found eight Cambro lids on the ground underneath the shelving and some small pieces of onion debris on the checkered blade portion of the chopper. In this area a review of a tub containing extra ladles found an accumulation of crumbs in the bottom of the container. According to the 2013 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. 6. During the initial tour of the facility, starting at 9:10 AM on 9/9/20, it was observed that numerous areas of the kitchen floor shown accumulation of debris. These areas were: the walk-in cooler floor where onion peels were found scattered underneath the storage racks with noticeable stagnant water in the back-left corner of the walk-in. Under the drink station a large amount of shattered glass and a potato was found, Dietician J stated Someone probably dropped a stack of cups. Observation under the cook line found large amounts of grease deposits under equipment, cleaning utensils (pipe cleaners for fryer), and food crumbs and dirt debris. According to the 2013 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.
F 0838 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interview and record review, the facility failed to complete a comprehensive facility-wide assessment that included an assessment of the staffing, acuity, training programs, policies/procedures, and health information technology resources. Findings include: Review of the facility policy Facility Assessment last revised 4/27/20 revealed, The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its' residents competently during both day to day operation and emergencies .1. The facility assessment will include but not limited to the following: a. The facility's resident population, including but not limited to; i. Number of residents and the facility's capacity; ii. The care required by the resident population considering the types of disease, condition, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within the population; iii. The staff competencies that are necessary to provide the level and types of care needed for the resident population .iv. All personnel, including manager, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; v. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and vi. Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. Review of the Facility Assessment revealed no assessment or evaluation of the facility's training program to ensure any training needs were met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The Facility Assessment did not include an evaluation of necessary policies and procedures needed for the provision of resident care. The Facility Assessment did not include an assessment that the existing policies and procedures met current professional standards of practice. The Facility Assessment did not include an evaluation of contracts during both normal operations and emergencies, did not address process for oversight of services, and did not evaluate and how those services meet resident needs as well as regulatory, operational, maintenance, and staff training requirements. The Facility Assessment did not address health information technology resources (such as managing resident records and electronically sharing information with other organizations), or address how the facility would securely transfer health information to a hospital, home health agency, or other providers for any resident transferred or discharged from the facility. The Facility Assessment did not evaluate the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs or include a competency-based approach to determine the knowledge and skills required among staff to ensure residents were able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. During an interview on 09/10/20 at 12:17 P.M., Director of Nursing (DON) B reported that resident acuity and staffing needs are assessed daily by the Unit Managers and the DON. DON B did not identify where acuity and staffing needs were assessed in the Facility Assessment prior to survey exit. DON B reported that the facility uses (Name Omitted) Company for staff education and it is completed online. DON B reported that a competency checklist is completed upon hiring staff and annually thereafter. DON B did not identify where staff competencies were assessed/evaluated in the Facility Assessment prior to survey exit. DON B reported that the overseeing of contracts is based on the department. DON B did not identify where contract evaluations were assessed in the Facility Assessment prior to survey exit. DON B did not identify where secure transfer of health information technology was assessed in the Facility Assessment prior to survey exit.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for 3 out of 12 residents (Resident #8, #13, and #25) reviewed for medical records, resulting in inaccurate and incomplete medical records and the potential for facility staff and providers not having all of the pertinent information to care for residents. Findings include: Review of the facility policy Prevention of Pressure Ulcers last revised 12/9/17 revealed, The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors .Review the resident's care plan to assess for any special needs of the resident .9. Routinely assess and document the condition of the resident's skin per Weekly Impaired Skin Assessment for any signs and symptoms of pressure ulcer development. Resident #8 Review of a Face Sheet revealed Resident #8 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #8's Physician Order dated 1/5/20 revealed, Skin Assessment, Vitals signs, Weight every evening shift every Wed(nesday). Review of Resident #8's Care Plan revealed, Skin Integrity .Administer meds and treatments as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 12/13/2019. Review of Resident #8's Treatment Administration Record (TAR) for July 2020 and August 2020 revealed, Skin Assessment, Vitals signs, Weight every evening shift every Wed(nesday). There were checkmarks in the boxes dated 7/8/20, 7/15/20, 7/22/20, 7/29/20, and 8/5/20 indicating the skin assessment task had been completed. Review of Resident #8's Weekly Skin Assessment revealed a skin assessment had been completed on 7/1/20 and was not completed again until 8/12/20. Review of Resident #8's Progress Notes revealed no documentation revealing why the Skin Assessments had not been completed. Resident #13 Review of a Face Sheet revealed Resident #13 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #13's Physician Order dated 7/24/19 revealed, Skin Assessment, Vitals signs, Weight every evening shift every Thu(rsday). Review of Resident #13's Care Plan revealed, Skin Integrity .Administer meds and treatments as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 7/24/2019. Follow facility Skin and Wound Management Policies and Procedures. Date Initiated: 07/24/2019. Review of Resident #13's TAR revealed, Skin Assessment, Vitals signs, Weight every evening shift every Thu(rsday). There was a 9 . Other / See Nurse Notes in the box for Resident #13's Skin Assessment on 9/3/20. Review of Resident #13's Weekly Skin Assessment revealed no skin assessment completed on 9/3/20. Review of Resident #13's Progress Notes revealed no progress notes to indicate why the Skin Assessment was not completed on 9/3/20. Resident #25 Review of a Face Sheet revealed Resident #25 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of Resident #25's Physician Order dated 1/24/20 revealed, Skin Assessment, Vitals signs, Weight every day shift every Fri(day). Review of Resident #25's Care Plan revealed, Skin Integrity

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) .Administer meds and treatments as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 10/10/2019. Review of Resident #25's TAR revealed, Skin Assessment, Vitals signs, Weight every day shift every Fri(day). There was a checkmark in the box for 8/28/20 indicating the skin assessment task had been completed and no checkmark in the box for 9/4/20 indicating the skin assessment task had not been completed. Review of Resident #25's Weekly Skin Assessment revealed no skin assessments had been completed since 8/21/20. Review of Resident #25's Progress Notes revealed no documentation revealing why the Skin Assessments had not been completed. During an interview on 9/9/20 at 12:57 P.M., Certified Nursing Assistant (CNA) F reported that nurses complete weekly skin assessments on the Residents' shower day. The assessments are documented in the Electronic Health Record (EHR) by the nurse. During an interview on 9/10/20 at 11:43 P.M., Registered Nurse (RN) C reported that skin assessments should be completed weekly for all residents in the facility.