STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235310	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTER HILLS HEALTH CENTER	3600 FULTON ST E GRAND RAPIDS, MI 49546

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to minimize the risk of scalding [MEDICAL CONDITION] allowing domestic hot water to exceed 120F. This resulted in an increased risk of injury among residents who are cognitively impaired. Findings Include: At 8:40 AM on 3/4/20 the hot water temperature of Spa 3 was taken and found to be 119F. An anti-scald mixing valve was observed underneath the sink to help temper the water. During an environmental tour of the facility starting at 10:35 AM on 3/4/20, with Maintenance and EVS Manager (MEM) K and Maintenance and EVS Director (MED) J, a review of room D-11 Mechanic, found the facilities hot water system. When asked what this system supplies water to, MED J stated, the kitchen and the laundry, then gets mixed for domestic use. A review of the thermometer, showing the temperature of domestic hot water for residents, was found exiting the boiler room at 125F. At this time, mixing valves were thought to be on all resident water fixtures. A review of resident room [ROOM NUMBER] at 1:55 PM on 3/4/20, found a hot water temperature of 124F with no anti-scald mixing valve on the faucet. The surveyor immediately took temperatures of the following rooms and found the following temperatures: room [ROOM NUMBER] at 125.2F, room [ROOM NUMBER] at 123.2, room [ROOM NUMBER] at 126.2F, and room [ROOM NUMBER] at 125F. The surveyor went down the hall to room [ROOM NUMBER], in order to check temperatures further away from the boiler, and found it to be 122F. At 2:14 PM on 3/4/20, MED J was notified of the high temperatures and stated Well have someone get on that mixing valve right now.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely medication administration to 1 of 7 residents (Resident #59) reviewed during medication administration resulting in a medication error rate of 20%. Findings include: Review of the Policy Liberalized Medication Pass dated 5/20/19 revealed, Liberalized Med(ication) pass or open med(ication) pass OMP will allow medications that do not require stringent adherence to a specific dosing schedule for therapeutic effectiveness to be given at a time that is convenient for the resident. The Policy further revealed a time frame of .Open Med Pass AM: 0700 AM- 1100 AM. Review of the Face Sheet revealed Resident #59 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #59 had a brief interview for mental status (BIMS) score of 14 out of 15 which indicated she was cognitively intact. Review of the physician's orders [REDACTED].#59 was ordered to be given [MEDICATION NAME] (medication for heart failure) 30 mg (milligram), [MEDICATION NAME] (blood pressure medication) 20 mg, [MEDICATION NAME] (medication for depression) 25 mg, [MEDICATION NAME] (blood pressure medication) 100 mg at AM 7 am (indicated hours between 7 am and 11 am) and [MEDICATION NAME] suspension (nasal medication to prevent breathing problems), at 0900 (indicated was to be given at 9:00 AM). In an observation on 03/04/20 at 11:14 AM, Resident #59 was administered [MEDICATION NAME] suspension, [MEDICATION NAME] 30 mg, [MEDICATION NAME] 100 mg, [MEDICATION NAME] 20 mg and [MEDICATION NAME] 25 mg by Registered Nurse (RN) TT (indicated not within the allotted time frame for medication administration). In an interview on 03/05/20 at 01:55 PM, Unit Manager (UM) MM stated medications were to be administered within .an hour each way (indicated 1 hour before and 1 hour after the ordered time). UM MM stated if the medication is liberalized then staff have .a window of time, if outside the window I would say no the medication should not be administered and the [MEDICATION NAME] (suspension) was at 9 am; you've (staff) got the hour window either way (indicated the [MEDICATION NAME] could be given correctly between 8 am and 10 am). In an interview on 03/05/20 at 02:06 PM, Director of Nursing (DON) B stated, there is open (liberalized) medication pass (administration) times during the morning the time frame is 7 am to 11 am. DON B stated, if the medication is scheduled then they have 1 hr before and after the scheduled administration time.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to store, label, date and remove expired medications from 2 of 3 medications carts reviewed during medication storage resulting in the potential for decreased efficacy of medications administered to residents. Findings include: Review of the Policy Storage of Medications dated 4/2017 revealed, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Review of the manufacturer guidelines for [MEDICATION NAME] ([MED] [MEDICATION NAME]) dated 2018 revealed, [MEDICATION NAME] .may remain in patient use at temperatures below 30C (86F) for 28 days. https://www.novo-pi.com/[MEDICATION NAME].pdf . In an observation on 03/03/20 at 11:57 AM, the North 2 medication cart was noted with Registered Nurse (RN) NN. Observed in the top drawer was a bottle of [MED] [MEDICATION NAME] with no open date on the bottle. Review of the American Diabetes Association revealed, .The manufacturer (of [MEDICATION NAME]) seemed to stress that patients not use a started bottle of this [MED] for > (greater than) 28 days. https://care.diabetesjournals.org/content/26/9/2665 Review of the Instruction for use [MED] ([MED]) dated 11/2019 revealed, Store opened vials in the refrigerator or at room temperature below 86F (30C) for up to 28 days. Keep vials away from heat and out of direct light. Throw away all opened vials after 28 days of use. http://pi.lilly.com/us/humalog-vial-ifu.pdf In an observation on 03/03/20 at 12:17 PM, the East Medication Cart was noted with Licensed Practical Nurse (LPN) LL. Observed in the top drawer was a bottle of [MEDICATION NAME] with no open date on the bottle, a bottle of [MED] ([MED]) with an open date of 1/27/20 (indicated was open for more than 28 days) and an open bottle of [MEDICATION NAME] with an open date of 1/9/20. In an interview on 03/03/20 at 12:17 PM, LPN LL stated the [MED] .should have a date on it and the [MED] [MED] .should be discarded and [MEDICATION NAME] was only good for 28 days so we'll get rid of these (outdated [MED] bottles). In an interview on 03/05/20 at 02:11 PM, Director of Nursing (DON) B stated, [MED] good for 28 daysand the staff .would have to discard it ([MED] bottle) and get a new vial (of [MED]).
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**

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) Based on observation, interview, and record review the facility failed to: 1. Properly store food product to prevent cross contamination; 2. Ensure cleanliness and proper storage of food and non-food contact surfaces; 3. Properly date mark and discard food products; 4. Use an approved sink for food preparation; 5. Properly store potentially hazardous food; and 6. Ensure proper transport of food product. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness that affected 76 residents who consume food from the kitchen. Findings Include: 1. During the initial tour of the main kitchen starting at 11:25 AM on [DATE], with Dining Services Director (DSD) L, a review of the dairy walk in cooler found an expediting rack with breakfast items ready and prepped for the next days' meal. On the rack it was observed that 10 sheet pans of raw bacon were stored above pre-cooked sausage patties and puree breakfast items. When asked what was wrong with this storage, DSD L stated, Raw items over prepared. According to the 2013 FDA Food Code section ,[DATE].11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(c) below, separating raw animal FOODS during storage, preparation, holding, and display from: .(b) Cooked READY-TO-EAT FOOD; .(b) Arranging each type of FOOD in EQUIPMENT so that cross contamination of one type with another is prevented . 2. During the initial tour of the main kitchen at 11:50 AM on [DATE], it was observed that a vegetable slicer was on the preparation table. When asked how often the slicer is used, Cook N stated, once or twice a week, for tomatoes. Review of the slicer found a few tomato seeds inside the metal slicer arm and on the bottom cutting board portion of the slicer. At 11:53 AM on [DATE], it was observed that a meat slicer was on the preparation table. When asked if the meat slicer was used today, Cook M stated, No. Observation of the slicer found a penny size piece of dried turkey looking meat on the top portion of metal, above the blade. When asked if they use the slicer for turkey, DSD L stated, Yes. An initial tour of the pantry, at 12:13 PM on [DATE], found non-food contact portions of the juice machine to be visibly soiled with orange and brown juice staining and accumulation. These areas were located on the black and white portions of the machine, underneath the spouts. A review of the main kitchen at 12:44 PM on [DATE], found a utensil drawer on the service line with stagnant water accumulation inside two mechanical scoops stored right-side up in the drawer. When ask if this is where clean utensils are stored, DSD L stated Yes. According to the 2013 FDA Food Code section ,[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2013 FDA Food Code section ,[DATE].11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD; . 3. During the initial tour of the Pantry starting at 12:13 PM on [DATE], a review of the single door reach in refrigeration unit found nearly two dozen supplement shakes and juices with no date to indicate discard. When asked if they should be dated, DSD L stated, They should have that two-week discard date. Review of the clean utility room at 2:45 PM on [DATE], found two cases of thickened apple juice with an expiration date of [DATE], two cases of thickened orange juice with an expiration date of [DATE], two cases of thickened cranberry juice with an expiration date of [DATE], and 9 bottles of expired thickened orange juice with an expiration date of [DATE]. An interview with Dietician F, found the intention was to use the thickened beverages for nursing. According to the 2013 FDA Food Code section ,[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. .(B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT . According to the 2013 FDA Food Code section ,[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in ,[DATE].17(A) or (B) shall be discarded if it:(1) Exceeds the temperature and time combination specified in ,[DATE].17(A) . 4. During a revisit of the main kitchen at 12:35 PM on [DATE], and interview with Cook M found that he uses the one compartment sink, between the cook lines, to wash potatoes. Observation of the waste line drain of the sink found it to be directly connected to the wastewater supply, with no air gap installed. According to the 2013 FDA Food Code section ,[DATE].11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed . 5. During an initial tour of the dry storage room at 12:50 PM on [DATE], found a half empty bottle of less sodium soy sauce on the dry storage shelf. Review of the manufactures label on the bottle states, Refrigerate After Opening. DSD L discarded the bottle. According to the 2013 FDA Food Code section ,[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 ,[DATE].19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (2) At 5C (41F) or less . 6. During an observation on [DATE] at 12:50 PM., observed Dining Server (DS) BB carrying a chaffing dish filled with a hot pasta dish. DS BB was using her left hand and had the chaffing dish leaning on her left hip, the top of the chaffing dish was touching her uniform. DS BB's right hand was carrying another plate which contained a salad. During an interview on [DATE] at 1:10 PM., DS BB reported when carrying any food items, chaffing dishes or plates, the item should not touch any part of staffs body, or clothing. DS BB reported she should have used both hands to carry the chaffing dish.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain a sanitry and clean environment in order to reduce the risk of contamination of clean and sanitary items stored in the facility. This resulted in an increased potential for contamination of sanitary items possibly affecting all 77 residents in the facility. Findings include: During a tour of the facility at 2:58 PM on 3/3/20, it was observed that the clean linen room, near resident room [ROOM NUMBER], was found with seven table cloths on the ground, one towel on ground, and a bucket against the back wall with staining and dripping on the back wall behind a clean linen cart. It was observed that the ceiling tile was pushed back to indicate a leak, but not current leak observed. During a tour of the laundry room at 9:35 AM on 3/4/20, it was observed that ventilation equipment, above the washers, was found rusted and chipping in many locations. At this time, the clean bin that is used to transport clean linen from the washers to the dryers was found with used gloves, used dining rags, linens, and tablecloths under the false floor. During an observation on 3/04/20 at 9:33 AM., room [ROOM NUMBER]'s call light was visibly soiled with dirt/grime in the crevasses. During an observation on 3/04/20 at 9:35 AM., observed room [ROOM NUMBER]'s call light button was visibly soiled with dirt/grime in the crevasses. During an observation on 3/04/20 at 9:37 AM., observed a vitals machine on theWest unit parked next to room [ROOM NUMBER]. The base of the machine was visibly soiled with dust and debris. The finger probe (which measures oxygen in the blood) was visibly soiled with dirt and grime. The cords to the computerized reading screen and blood pressure cuffs were hanging off the machine, coiled around each other, and had an overall dingy, dirty appearance. During an observation on 3/04/20 at 9:41 AM., observed a toilet riser in the bathroom of room [ROOM NUMBER] had a brown smudge of dried feces on it. During an observation on 3/04/20 at 9:44 AM., observed the call light in room [ROOM NUMBER], which was visibly soiled with dirt and grime, in the bathroom of room [ROOM NUMBER] the toilet was filled with feces, and the toilet seat was visibly soiled. The sink vanity was visibly soiled with a dark dried substance near the front of the sink. During an observation on 3/04/20 at 9:52 AM., observed the call light in room [ROOM NUMBER] which was laying on the floor, the call light handle and button were visibly soiled with dirt and grime in the crevasses. During an observation on 3/04/20 at 9:55 AM., observed the call light in room [ROOM NUMBER] on West unit, the call light cord was laying across the floor to the foot of the bed. The actual call light handle/button was inside a garbage can which was filled with various items of trash. The call light cord, was visibly soiled with a dingy appearance. Observe in the room, a tube feeding pole's base was visibly soiled with dried, crusted liquid spillage, The pole for the tube feeding also had dried crusted tube feeding spillage/splatter, and the face to the computerized screen was covered with grime, and

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) fingerprints. During an observation on 3/04/20 at 10:17 AM., observed a staff laptop on a wheeled desk (workstation on wheels-WOW). Observed the base of the WOW was visibly soiled with dust and debris, the mouse, keyboard and desk which held the laptop was visibly soiled with dust, debris an food crumbs. During an observation on 3/04/20 at 10:21 AM., observed a medication cart on the West unit nurses station. On the medication cart was a pill crusher, the pill crusher was heavily soiled with dust, debris from crushed medications, and dried, encrusted stuck on substance. During an observation on 3/04/20 at 10:29 AM., observed a sit to stand lift on the West unit near the nurses station. The base of the stand where residents plant their feet, was visibly soiled with dust and debris, the blue pads for the knee, and buttock area were visibly soiled with dirt and grime, with an overall dingy appearance, along with a white stuck on substance in various areas on the blue padding. During an observation on 3/04/20 at 10:51 AM., observed a hoyer lift parked next to room [ROOM NUMBER], the handles, remote control and lift mechanism were visibly soiled with dust and grime, there was a heavy accumulation of a white liquid substance on various areas of the lift. During an observation on 3/04/20 at 11:00 AM., observed a sit to stand lift parked near North unit labeled #5. The base of the lift was soiled with dust and debris, the handles had a grimy, sticky substance on them, and the remote control was visibly soiled. The blue padded areas where resident knees go, had areas of dried, crusted on spillage. During an observation on 3/04/20 at 11:09 AM., observed room [ROOM NUMBER]-B on the North unit the call light laying on the floor under the bed. The call light cord was visibly soiled with a dingy appearance, and the call light button was soiled with dirt and grime. During an observation on 03/04/20 11:21 AM., observed in room [ROOM NUMBER] on the North unit bed-b the call light was visibly soiled with dirt and grime in the crevasses. The bathroom toilet riser had an accumulation of urine stained areas, along with an accumulation of a white substance underneath the toilet seat, and in the bowl. The toilet seat itself, had screw holes (8), which had a rusty color in and around the holes. During an observation on 3/04/20 at 11:12 AM., observed a medication cart parked next to room [ROOM NUMBER] on the North unit. The stethoscope hanging on the handle was noted to be soiled on the ear pieces, as well as a heavily soiled piece of dingy medical tape with black marker which was unreadable, and smudged. During an observation on 3/04/20 at 11:33 AM., observed a sit to stand on the North unit parked next to room [ROOM NUMBER]. The blue padded areas for the arms, and knee areas were visibly soiled with an accumulation of grime, the base area where residents plant their feet, was visibly soiled with a dingy appearance. During an observation on 3/05/20 at 8:31 AM., observed a sit to stand lift on the West unit parked next to room [ROOM NUMBER]. The base of the lift was visibly soiled with food crumbs. During an observation on 3/05/20 at 8:36 AM., observed a vitals machine at the nurses desk on the East unit. The finger probe was noted to be soiled with an oily substance on the outside area, on the inside observed dirt and grime. During an interview on 3/05/20 at 8:37 AM., Licensed Practical Nurse (LPN) CC reported that any staff including nurses and CNA's are to wipe and sanitize resident shared equipment between uses. During an interview on 3/05/20 at 8:40 AM., Housekeeper (Hsk) DD reported when housekeepers enter into resident rooms housekeepers are to wipe down tv tables, and sanitize items that are touched frequently. Hsk DD reported call lights should be wiped down and sanitized daily. During an observation on 3/05/20 at 8:45 AM., observed a sit to stand lift parked near North unit room [ROOM NUMBER]. The base of the lift had dust and debris, the blue padded area where residents place their knees to stabilize was visibly soiled. During an observation on 3/05/20 at 8:59 AM., observed on the North unit a hoyer lift parked outside room [ROOM NUMBER], The padded blue knee area was visibly soiled with a dried, crusted white substance. During an observation/interview on 3/05/20 at 12:25 PM., observed a open clean linen closet on North unit. 2 blankets were on the floor, which was visibly soiled. The garbage bag was full, and there were oblong pieces of plastic approximately 10 inches in length were laying on the floor. Hsk DD was walking by, and informed this surveyor that nothing, including the blankets should be stored on the floor. Hsk DD shut the door and walked away without picking the blankets up. During an observation/interview on 3/05/20 at 12:29 PM., Environmental Services (EVS) HH observed a open clean linen closet on North unit. 2 blankets were on the floor,which was visibly soiled. EVS HH reported nothing should be stored on the floor, and the blankets did not belong on the floor. EVS HH shut the door and walked away, EVS HH did not pick the blankets up from the floor. During an interview on 3/05/20 at 12:40 PM., EVS Manager (EVS-M) II reported resident shared equipment is to be cleaned by the nursing staff (CNA's/Nurses). EVS-M II reported as for the clean linen rooms/areas, staff should not store items down on the floor. EVS-M II reported the linen rooms are checked daily. EVS-M II indicated he two staff members who saw the blankets on the floor should have picked them up, and sent them to be laundered. During an observation on 03/04/20 13:40 PM, observed in room [ROOM NUMBER] on the North unit bed-A the call light was visibly soiled with brownish/red smear along the side of the casement around the button. During an observation on 03/04/20 13:40 PM, observed in room [ROOM NUMBER] on the North unit bed-B the call light was visibly soiled with dirt and grime in the crevasses.