STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235027	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton County Medical Care Faci	530 W Beech St Charlotte, MI 48813

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on interview and record review, the facility failed to ensure updated and accurate advanced directive information was in place for 1 residents (#329) of 2 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time), resulting in the potential for a resident's preferences for medical care to not be followed by the facility, or other healthcare providers potentially affecting up to the facility census of 127 residents. Findings include: Review of the MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT, Act 193 of 1996 revealed that, An order executed under this section shall be on a form described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: (a) The declarant, the declarant's patient advocate, or another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the directions of the declarant. (b) The declarant's attending physician. (c) Two witnesses [AGE] years of age or older, at least 1 of whom is not the declarant's spouse, parent, child, grandchild, sibling, or presumptive heir. (3) The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud, or undue influence. Review of R329 physician signed DNR order, dated 12/13/24, reflected the document was signed by R329 responsible party on 12/11/24 and included one witness signature.(document was missing second witness signature and date. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 3:50 pm, Admission coordinator(AC) S reported the facility process for completing DNR order on admission included resident or responsible party was required to sign along with two witnesses and physician. AC S reported two witnesses required to verify resident wishes being honored. During an interview on 12/18/24 at 4:20 PM, Palliative Care Clinical Mentor (CM) T reported admission nurse was responsible for completing DNR documents with resident/responsible party. CM T reported DNR order should include two witnesses and verified R329's was missing a witness statement.

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NAME OF PROVIDER OR SUPPLIER Eaton County Medical Care Faci		STREET ADDRESS, CITY, STATE, ZIP CODE 530 W Beech St Charlotte, MI 48813	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act 42CFR483. 12(c) Findings include: Resident #22 (R#22) Review of the medical record reflected R22 was an initial admission to the facility on [DATE] with a readmission on 10/03/24. Diagnoses of Paraplegia, Vascular Dementia, Speech and Language deficits following other Diagnosis, Cerebrovascular Disease, Dysphagia Oropharyngeal Phase, Weakness and Pathological Fracture, left Humerus, subsequent Fracture with routine healing. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/16/2024, revealed R22 had a Brief Interview of Mental Status (BIMS) of 99 (count not answer) out of 0 to 15. Under section G0100, Activities of Daily Living (ADL) assistance reveals R22 was dependent of all care. During an interview on 12/18/24 at 08:35 AM, family member Y stated that R22 suffered a broken arm, and nobody knew why, she had asked and did not get any answers. Record review revealed R22 had an X-Ray due to aspiration pneumonia on 12/11/24 and the fracture to the left shoulder was found incidentally. Order dated 12/11/2024 00:24, Physician's Order Note Data: CXR results received: Conclusion: 1. No acute focal consolidation or effusion. 2. No significant change from comparison imaging. 3. left humeral neck fracture, possibly pathologic. Recommend shoulder radiographs and/or CT versus MRI. Action: Notified physician Response: New orders: STAT left shoulder XR. Resident to be non-weight bearing to left arm until results of left shoulder XR. Record review revealed 12/11/2024 08:00. Incident/Accident Note (name of facility): Resident found to have a possible pathologic L humerus fracture as an incidental finding on chest x-ray. Resident has no complaints or signs/symptoms of pain or discomfort. X ray completed stat of left shoulder, findings confirmed, resident sent to emergency room per physician order. Record review revealed on 12/11/2024 08:39. Physician's Order Note Data: Results of left shoulder 2-view X-ray: Proximal left humeral fx. Action: RN called physician to notify of above results. Response: Physician stated to send resident to local emergency room for further evaluation/treatment. Record review revealed on 12/11/2024 08:42. Nurse's Note Describe observation/situation: Registered Nurse (RN) called resident's daughter (DPOA/legal guardian) to notify her of results of left shoulder X-ray. Informed her that X-ray positive for left humeral fracture, and that physician ordered to send resident to local emergency department for further evaluation/treatment. Resident's daughter agreeable with sending him to the local emergency department. Resident to be sent to local emergency department and daughter stated she will meet him there. Resident's daughter verbalized understanding of all information given. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Eaton County Medical Care Faci		STREET ADDRESS, CITY, STATE, ZIP CODE 530 W Beech St Charlotte, MI 48813	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed on 12/11/2024 09:00. Nurse's Note Describe observation/situation: RN called county 911 to transport resident to local emergency department. Record review revealed on 12/11/2024 09:20. Nurse's Note. Describe observation/situation: Report called to local emergency department. Record review revealed on 12/11/2024 12:45. Nurse's Note. Describe observation/situation: resident returned from local emergency department. Record review revealed on 12/11/2024 14:50. Physician's Order Note Data: Results: There is a fracture through the humeral neck without significant angulation or displacement. Correlate clinically in regard to the age of this fracture as it may be acute/subacute. Degenerative Joint Disease. Conclusion: Proximal left humeral fracture. Action: NP reviewed and provided orders for non-weight bearing, no laying on left side, 2 persons with check and change for stabilization of left upper extremity, no mechanical lift. Record review revealed on 12/12/2024 04:58. Incident/Accident Note (name of facility): Resident is resting in bed quietly with no complaints of pain or discomfort at this time. Will continue to monitor. Record review revealed on 12/12/2024 14:25. Incident/Accident Note (name of facility): Resident complained of left arm pain seems to be located more around left elbow. left arm is contracted with elbow bent towards chest, Little to no range of motion. No left side lying. During an interview on 12/18/24 at 12:15 PM, writer asked LNA A if she had an incident report on this injury of unknown origin and the investigation. Record review revealed minimal details in the resident's electronic medical records. On 12/18/24 at 3:00pm, writer was still waiting for information of the incident report and investigation. Record review of the incident/ investigation revealed that was an injury of unknown origin. Information received on12/18/24 by LNA A included an incident report, physician review of injury, a new progress note dated 12/17/24 by Director of Nursing (DON) B within 16 pages. There was not an investigation completed. On 12/19/24 at 08:25 AM, writer requested full incident report and investigation again from the LNA A for the third time. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 08:30 AM, Record review of the updated incident with investigation presented now contains 91 pages of information from the incident, physician review of injury dated 12/16/24, event investigation completed by the DON B, grievance/concern witness statement form dated 12/18/24 by CNA Z, grievance/concern witness statement form dated 12/19/24 by Registered Nurse (RN) AA, grievance/concern witness statement form dated 12/18/24 by Clinical Mentor BB. Incident statement form dated 12/11/24 by Clinical Mentor BB. Incident statement form dated 12/18/24 by CNA CC with the 18th date crossed out and 11 written over it. Incident statement form dated 12/18/24 by Hospitality Aide/ Nurse Aide in Training DD with the 18th date crossed out and 11 written over it. Incident statement form dated 12/18/24 by Restorative CNA EE with the 18th date crossed out and 11 written over it. Record review included a Radiology report dated 12/11/24 showing the fractured left humerus neck fracture. After visit report from emergency department of closed 2-part nondisplaced fracture to the surgical neck of the humerus. Kardex updated 12/13/24. Care plan of 22 pages updated on 12/13/24 for a focus of R22 had a possible pathological left humerus neck fracture discovered by incidental finding on chest x-ray, only intervention on care plan was Resident's left arm to be supported by staff when proving care dated 12/13/24. Every hour repositioning of resident and offload only on right side related to left arm humerus fracture. No other interventions updated on the care plan. No resident interviews included in the investigation plan. Presented investigation was completed after the incident and forms filled in during the annual survey. During an interview on 12/19/24 at 11:00 AM, R22 stated he has pain in his left arm. Stated he fell , when asked questions about the fractured left arm he could only shake his head yes or no. Refused to let writer look at his left arm. When asked if staff reposition him every hour, he shook his head no. R22 could use the bed controller to put his bed in a reclined position so he could rest. Writer asked him if he wanted to rest, R22 shock his head yes, so writer told R22 that I would come back later. During an interview on 12/20/24 at 08:54 AM, RN Clinical Mentor BB stated she couldn't give much information as it was incidental findings, she asked for an Xray of his lungs, it was done on the 10th, nurse called the Medical Director (MD), ordered a stat Xray on left shoulder, results came in early on the 11th, MD contacted, MD sent him out to the emergency room , contacted daughter, who would meet resident at the local emergency department. R22 came back to the facility after several hours. Writer asked about the investigation on the injury. Clinical Mentor BB stated when a resident gets an injury on that unit, they start getting statements, talking to staff working that shift, had to be an immediate intervention, MD and family contacted, DON B and LNA A notified. Immediate intervention was he was sent to the emergency department and mobilized the arm. Clinical Mentor BB stated the interventions are case by case. In this case, he didn't come out of his room, another resident would not witness it because the door is shut. Other residents are good reporters, they are alert & oriented to what's going on. Clinical Mentor BB stated she didn't think it was abuse, because there was no bruising, not found on the floor, he would have other marks on his skin, scratching, etc. Medical Director and Nurse Practitioner believed it was a pathological explanation of this injury. Clinical Mentor BB stated nothing indicated to make her suspicious of anything. Clinical Mentor BB added that part of the investigation would be to start an incident packet, a resident event review. Clinical Mentor BB stated they were unable to find how this happened, she did skin assessment weekly, every Tuesday, yesterday R22 had pain in his right hip, he did not speak, she answered his call light, complained of pain, can node his head to answer yes or no. Provides protection to left elbow, hand protector. Offloading boots were on, no skin issues, no bruising. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/24 at 09:30 AM, DON B stated anytime there is an injury, they complete an Incident and accident report, notify the MD, complete an assessment. DON B added that they figure in any factors that could have caused the injury, complete skin assessments, pain assessment, staff statements, course of events that lead to the incident. Set up repeat assessments, pain assessments, skin assessments, labs, updating the care plan based on need to add interventions. DON B stated they notify the family and shared this event in the interdisciplinary team (IDT) meeting every morning. During an interview on 12/20/24 at 10:58 AM, LNA A stated that staff contact her when there is an injury, if it's not suspicious it comes to her, or an allegation, means unwitnessed injury. LNA A then stated if it is suspicious, she would ask questions around the incident, determine if it's an allegation of abuse or neglect, report to social worker. LNA A added, depending if its abuse and neglect, social worker and nurse manager will discuss with the staff working on the floor, depends on the situation or incident. LNA A stated it depends on what they are investigating, then they may interview other residents. Social worker would interview other residents to see if they feel safe. If not an allegation of abuse or neglect, they would not interview residents. LNA A stated she was notified that morning of incident, was told he had a pathological fracture. Writer asked if there was an allegation of abuse or neglect. LNA A stated she did not feel it was abuse or neglect, so they did not feel the need to investigate or report this incident to the state. LNA A stated she had no concerns; BB had been his clinical mentor for years. LNA A stated she reports it only if it's an allegation of abuse or neglect, if not no.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on interview and record review, the facility failed to ensure all injuries of unknown source were thoroughly investigated, in one of one resident (R#22) reviewed for abuse, resulting in the potential for injuries of unknown origin not being investigated. Findings include: Resident #22 (R#22) Review of the medical record reflected R22 was an initial admission to the facility on [DATE] with a readmission on 10/03/24. Diagnoses of Paraplegia, Vascular Dementia, Speech and Language deficits following other Diagnosis, Cerebrovascular Disease, Dysphagia Oropharyngeal Phase, Weakness and Pathological Fracture, left Humerus, subsequent Fracture with routine healing. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/16/2024, revealed R22 had a Brief Interview of Mental Status (BIMS) of 99 (could not answer) out of 0 to 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R22 is dependent of all care. During an interview on 12/18/24 at 08:35 AM, family member Y stated that R22 suffered a broken arm, and nobody knew why, she had asked and did not get any answers. Record review revealed R22 had an X-Ray due to aspiration pneumonia on 12/11/24 and the fracture to the left shoulder was found incidentally. Order dated 12/11/2024 00:24, Physician's Order Note Data: CXR results received: Conclusion: 1. No acute focal consolidation or effusion. 2. No significant change from comparison imaging. 3. left humeral neck fracture, possibly pathologic. Recommend shoulder radiographs and/or CT versus MRI. Action: Notified physician Response: New orders: STAT left shoulder XR. Resident to be non-weight bearing to left arm until results of left shoulder fracture. Record review revealed 12/11/2024 08:00. Incident/Accident Note (Name of facility): Resident found to have a possible pathologic L humerus fracture as an incidental finding on chest x-ray. Resident has no complaints or signs/symptoms of pain or discomfort. X ray completed stat of left shoulder, findings confirmed, resident sent to emergency room per physician order. Record review revealed on 12/11/2024 08:39. Physician's Order Note Data: Results of left shoulder 2-view X-ray: Proximal left humeral fx. Action: RN called physician to notify of above results. Response: Physician stated to send resident to local emergency department for further evaluation/treatment. Record review revealed on 12/11/2024 08:42. Nurse's Note Describe observation/situation: RN called resident's daughter (DPOA/legal guardian) to notify her of results of left shoulder X-ray. Informed her that X-ray positive for left humeral fracture, and that physician ordered to send resident to local emergency department for further evaluation/treatment. Resident's daughter agreeable with sending him to the local emergency department. Resident to be sent to local emergency department and daughter stated she will meet him there. Resident's daughter verbalized understanding of all information given. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed on 12/11/2024 09:00. Nurse's Note Describe observation/situation: RN called county 911 to transport resident to local emergency department. Record review revealed on 12/11/2024 09:20. Nurse's Note. Describe observation/situation: Report called to local emergency department. Record review revealed on 12/11/2024 12:45. Nurse's Note. Describe observation/situation: resident returned from emergency department. Record review revealed on 12/11/2024 14:50. Physician's Order Note Data: Results: There is a fracture through the humeral neck without significant angulation or displacement. Correlate clinically in regard to the age of this fracture as it may be acute/subacute. Degenerative Joint Disease. Conclusion: Proximal left humeral fracture. Action: NP reviewed and provided orders for non-weight bearing, no laying on left side, 2 persons with check and change for stabilization of left upper extremity, no mechanical lift. Record review revealed on 12/12/2024 04:58. Incident/Accident Note (Name of facility): Resident is resting in bed quietly with no complaints of pain or discomfort at this time. Will continue to monitor. Record review revealed on 12/12/2024 14:25. Incident/Accident Note (Name of facility): Resident complained of left arm pain seems to be located more around lt. elbow. left arm is contracted with elbow bent towards chest, Little to no range of motion. No left side lying. During an interview on 12/18/24 at 12:15 PM, writer asked LNA A if she had an incident report on this injury of unknown origin and the investigation. Record review revealed minimal details in the resident's electronic medical records. On 12/18/24 at 3:00pm, writer was still waiting for information of the incident report and investigation. Record review of the incident/ investigation revealed that was an injury of unknown origin. Information received on 12/18/24 by LNA A included an incident report, physician review of injury, a new progress note dated 12/17/24 by Director of Nursing (DON) B within 16 pages. There was not a completed investigation. On 12/19/24 at 08:25 AM, writer requested full incident report with investigation again from the LNA A for the third time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 08:30 AM, Record review of the updated incident with investigation presented now contains 91 pages of information from the incident, physician review of injury dated 12/16/24, event investigation completed by the DON B, grievance/concern witness statement form dated 12/18/24 by CNA Z, grievance/concern witness statement form dated 12/19/24 by Registered Nurse (RN) AA, grievance/concern witness statement form dated 12/18/24 by Clinical Mentor BB. Incident statement form dated 12/11/24 by Clinical Mentor BB. Incident statement form dated 12/18/24 by CNA CC with the 18th date crossed out and 11 written over it. Incident statement form dated 12/18/24 by Hospitality Aide/ Nurse Aide in Training DD with the 18th date crossed out and 11 written over it. Incident statement form dated 12/18/24 by Restorative CNA EE with the 18th date crossed out and 11 written over it. Record review included a Radiology report dated 12/11/24 showing the fractured left humerus neck fracture. After visit report from emergency department of closed 2-part nondisplaced fracture to the surgical neck of the humerus. Kardex updated 12/13/24. Care plan of 22 pages updated on 12/13/24 for a focus of R22 had a pathological left humerus neck fracture discovered by incidental finding on chest x-ray, only intervention on care plan was Resident's left arm to be supported by staff when proving care dated 12/13/24. Every hour repositioning of resident and offload only on right side related to left arm humerus fracture. No other interventions updated on the care plan. No resident interviews included in the investigation. Presented investigation was completed after the incident and forms filled in during the annual survey. During an interview on 12/19/24 at 11:00 AM, R22 stated he has pain in his left arm. Stated he fell , when asked questions about the fractured left arm he could only shake his head yes or no. Refused to let writer look at his left arm. When asked if staff reposition him every hour, he shook his head no. R22 could use the bed controller to put his bed in a reclined position so he could rest. Writer asked him if he wanted to rest, R22 shock his head yes, so writer told R22 that I would come back later. During an interview on 12/20/24 at 08:54 AM, RN Clinical Mentor BB stated she couldn't give much information as it was incidental findings, she asked for an Xray of his lungs, it was done on the 10Th, nurse called the Medical Director (MD), ordered a stat Xray on left shoulder, results came in early on the 11th, MD contacted, MD sent him out to the local emergency department, contacted daughter, who would meet resident at the local emergency department. R22 came back to the facility after several hours. Writer asked about the investigation on the injury. Clinical Mentor BB stated when a resident gets an injury on that unit, they start getting statements, talking to staff working that shift, had to be an immediate intervention, MD and family contacted, DON B and LNA A notified. Immediate intervention was he was sent to the local emergency department and mobilized the arm. Clinical Mentor BB stated the interventions are case by case. In this case, he doesn't come out of his room, another resident would not witness it because the door is shut. Other residents are good reporters, they are alert & oriented to what's going on. Clinical Mentor BB stated she didn't think it was abuse, because there was no bruising, not found on the floor, he would have other marks on his skin, scratching, etc. Medical Director and Nurse Practitioner believed it was a pathological explanation of this injury. Clinical Mentor BB stated nothing indicated to make her suspicious of anything. Clinical Mentor BB added that part of the investigation would be to start an incident packet, a resident event review. Clinical Mentor BB stated they were unable to find how this happened, she did skin assessment weekly, every Tuesday, yesterday R22 had pain in his right hip, he did not speak, she answered his call light, complained of pain, can node his head to answer yes or no. Provides protection to left elbow, hand protector. Offloading boots were on, no skin issues, no bruising. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/24 at 09:30 AM, DON B stated anytime there is an injury, they complete an Incident and Accident report, notify the MD, complete an assessment. DON B added that they figure in any factors that could have caused the injury, complete skin assessments, pain assessment, staff statements, course of events that lead to the incident. Set up repeat assessments, pain assessments, skin assessments, labs, updating the care plan based on need to add interventions. DON B stated they notify the family and shared this event in the interdisciplinary team (IDT) meeting every morning. During an interview on 12/20/24 at 10:58 AM, LNA A stated that staff contact her when there is an injury, if it's not suspicious comes to her, or an allegation, means unwitnessed injury. LNA A then stated if it is suspicious, she ask questions around the incident, determine if it's an allegation of abuse or neglect, report to social worker. LNA A added, depending if its abuse and neglect, social worker and nurse manager will discuss with the staff working on the floor, depends on the situation or incident. LNA A stated it depends on what they are investigating, they may interview other residents. Social worker would interview other residents to see if they feel safe. If not an allegation of abuse or neglect, they would not interview residents. LNA A stated she was notified that morning of incident, told he had a pathological fracture. Writer asked if there was an allegation of abuse or neglect. LNA A stated she did not feel it was abuse or neglect, so they did not feel the need to investigate or report this incident to the state. LNA A stated she had no concerns; BB had been his clinical mentor for years. LNA A stated she reports it only if it's an allegation of abuse or neglect, if not no.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45038 Based on observation, interview, and record review the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one resident (#20) of 21 residents reviewed for accurate assessments. Findings Included: Resident #20 (R20) Review of the medical record revealed R20 was admitted to the facility 07/13/2018 with diagnoses that included heart failure, chronic kidney disease, end stage renal disease, dependence on renal dialysis, atrial fibrillation, type 2 diabetes, peripheral vascular disease (PVD), hypothyroidism (low thyroid hormone), atherosclerosis (plaque in arteries), hypotension, pneumonia, insomnia, depression, anemia (low red blood cells), and anxiety. The most recent Minimum Data Set (MDS), with an Assessment Reference Date of 09/18/2024, revealed R20 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 12/18/2024 at 08:55 a.m. R20 was observed sitting up in a chair beside her bed. R20 explained that she had been hospitalized in January of 2024 because she had COVID-19. R20 denied that she ever had pneumonia. Review of R20's medical record demonstrated Section I (Active Diagnoses) of the Minimum Data Set (MDS), with an Assessment Reference Date of 09/18/2024, revealed subsection I2000 (pneumonia) had been document as yes. Review of R20's diagnoses record revealed pneumonia which had been added to the diagnoses record on 01/12/2024 and did not have any list that diagnoses had been resolved. Review of the discharge summary dated 01/12/2024 revealed a diagnosis of pneumonia. Review of Centers for Medicare/Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3. 0 Manual Section I revealed I: Active Diagnoses in the Last 7 Days- Active Diagnoses in the last y days- check all that apply In an interview on 12/19/2024 at 09:40 a.m. Minimum Data Set (MDS) Nurse L confirmed that R20's MDS, with an Assessment Reference Date (ARD) of 09/18/2024, revealed that R20 had an active diagnosis of pneumonia. MDS Nurse L also confirmed that the diagnoses of pneumonia was added to R20's diagnoses record on 01/12/2024. MDS L could not demonstrate any other documentation that R20 had pneumonia in the last seven days of the MDS ARD of 09/18/2024. In an interview on 12/19/2024 at 10:21 a.m. Minimum Data Set (MDS) Nurse L explained that R20's MDS, with an Assessment Reference Date (ARD) of 09/18/2024 was incorrect because of the diagnoses of pneumonia and a corrected MDS had been completed and re-submitted to Center for Medicare/Medicaid Services (CMS).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to complete adequate monitoring for the use of an anticoagulant (blood thinner) medication for one (R100) of five reviewed. Findings include: Review of the medical record revealed R100 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed R100 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician' Order dated 11/11/24 revealed an order for Coumadin (blood thinner medication) 8. 5 milligrams (mg) at bedtime for atrial fibrillation. Review of the Physician's Order dated 10/4/24 revealed an order to check PT/INR (prothrombin time/international normalized ratio-measures how long it takes the blood to clot) every Monday. Review of the Physician's Order Note dated 12/9/24 revealed Reviewed PTINR with provider .continue with same dose of coumadin [every day at bedtime] and recheck on [Wednesday] and Friday due to [antibiotic] extension. Review of the Physician's Order dated 12/9/24 revealed an order for PT/INR Wednesday and Friday 12/11/24 and 12/13/24. This was in addition to R100's standing order of a PT/INR every week on Mondays. Review of the medical record revealed R100 did not have a PT/INR documented as completed with results on 12/11/24 and 12/13/24. On 12/19/24 at 10:48 AM, Nursing Home Administrator (NHA) A reported PT/INR results should be documented in the progress notes and physician's orders. In an interview on 12/19/24 at 11:06 AM, Clinical Mentor (CM) E reported R100's PT/INR tests on 12/11/24 and 12/13/24 were not completed. CM E reported the Physician's Order was entered incorrectly as a therapy order instead of a nursing order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to ensure their medication error rate was below 5% when five medication errors were observed from a total of 35 opportunities for four residents (R42, R58, R100, and R129) of seven reviewed resulting in a medication error rate of 14.29%. Findings include: Resident 100 (R100) Review of the medical record revealed R100 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed R100 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/19/24 at 7:53 AM, Licensed Practical Nurse (LPN) D was observed preparing and administering medications to R100. LPN D measured 17 grams of Miralax (laxative medication) powder and placed the powder in a plastic cup. R100 was seated at a dining room table eating breakfast and had some coffee in a cup. LPN D handed R100 the cup of Miralax powder. R100 then poured the powder into their oatmeal, mixed it, and then consumed the oatmeal. R100 reported they did not want to waste my fluids (R100 was on a fluid restriction) on their medications. LPN D reported R100 usually mixed the Miralax powder in their oatmeal. Review of the Physician's Order Note dated 12/18/24 revealed Patient would like MiraLAX increased .okay to increase MiraLAX 17 gram [twice a day]. Review of the Physician's Order dated 12/18/24 revealed an order for Miralax 17 grams by mouth two times a day for constipation, mix with 4 to 8 ounces of water or juice. The order did not specify if the medication was included in or in addition to R100's fluid restriction. Resident # 58 (R58) Review of the medical record revealed R58 was admitted to the facility on [DATE]. The MDS with an ARD of 9/25/24 revealed R58 scored 15 out of 15 on the BIMS. On 12/19/24 at 8:00 AM, LPN D was observed preparing and administering medications to R58. LPN D administered two tablets of Geri-kot (sennosides 8.6 milligrams) to R100. The medication given did not include docusate sodium 50 milligrams (mg). Review of the Physician's order dated 9/22/23 revealed an order for Senna-Docusate Sodium oral tablet 8. 6-50 mg, give 2 tablets by mouth two times a day for constipation. In an interview on 12/19/24 at 11:06 AM, Clinical Mentor (CM) E reported Miralax should be mixed with 4 ounces of a water or other beverage. CM E reported they were not aware R100 mixed their Miralax with oatmeal. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/19/24 at 12:00 PM, Director of Nursing (DON) B reported the dietitian usually considered all fluids given with medications when calculating fluid restriction amounts. DON B reported Miralax should not be mixed with food/oatmeal unless it was approved or there was a specific reason. DON B reported the facility stocked both sennosides and Senna-Docusate Sodium. According to www.miralax.com, directions included stir and dissolve in any 4 to 8 ounces of beverage (cold, hot or room temperature), then drink. Do not combine with starch-based thickeners used for difficulty swallowing. 34705 Resident #42(R42) Review of the medical record revealed R42 was admitted to the facility on [DATE]. R42 Face Sheet reflected diagnoses that included psychotic disorder with delusions, personality disorder, major depressive disorder, anxiety disorder and mood disorder. During an observation on 12/19/24 at 7:40 am, Licensed Practical Nurse (LPN) U administered R42 Cymbalta Delayed Release 60mg, after opening capsule and placing contents in yogurt. Review of R42 Physician Order, dated 9/11/24, reflected, Cymbalta Capsule Delayed Release Particles (DULoxetineHCl)Give 60 mg by mouth one time a day related to MAJOR DEPRESSIVE DISORDER . Resident R129(R129) Review of the medical record revealed R129 was admitted to the facility on [DATE]. R129 Face Sheet reflected diagnoses that included vitamin D deficiency, and Osteoarthritis. Review of R129 Physician order, dated 12/18/24, reflected, Calcium Oral Tablet 500 MG(Calcium)Give 1 tablet by mouth two times a day related to VITAMIN D DEFICIENCY . Gabapentin 300mg three times daily. During an observation on 12/19/24 at 8:30 p.m., LPN V prepared Calcium 500mg with vitamin D 1 tablet for R129. After surveyor verbally read physician order out loud LPN V reported would wait to administer Calcium with vitamin D because physician order was for just Calcium that was not available in medication cart and removed from the medication cup. (LPN V planned to administer prior to surveyor influence). Continued observation revealed LPN V administered R129 Gabapentin 300 mg one capsule. Review of R129 Medication Administration Record(MAR) on 12/19/24 at 11:50 AM, reflected R129 had received second dose of gabapentin 300 mg on 12/19/24.(First dose observed given at 8:31 a.m.) During an interview on 12/19/24 at 12:26 PM, LPN V reported administered R129 second dose of Gabapentin 300 mg at 11:16 a.m. after review of R129 MAR. During an interview and observation on 12/19/24 at 1:30 PM, LPN U reported no crush medication list was usually in book at the Nurse Station and verified was unable to locate in binder. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 12/19/24 at 1:45 PM, Registered Nurse(RN) W do not crush medication list was usually located in the folder on the medication cart and verified was missing. RN W reported would always call pharmacy if needed. During an interview on 12/19/24 at 2:30 PM, Director of Nursing (DON) B reported would expect that Cymbalta Delayed released capsule not be opened prior to administering. DON B reported would expect R129 Gabapentin 300mg be administered about every six hours three times daily. During an interview on 12/20/24 at 10:10 AM, DON B reported would expect nurses to follow physician medication orders.

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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. 34705 Based on observation and interview, the facility failed to dispose of expired medications in two of four medication carts, appropriately store refrigerated medications in one of three medication storage rooms reviewed, and secure medications (R97), resulting in the potential for decreased efficacy of medications, medication contamination, medication errors and adverse side effects in a current facility census of 127 residents. Findings include: Review of the facility provided medication cart and room map reflected 6 medication rooms and 7 medication carts. During an observation on 12/19/24 at 1:48 PM, Registered Nurse(RN) W unlocked the, rehab high medication cart. Located in the cart was an open bottle of Benadryl 25mg with manufacture expiration dated of 10/2024 and Insta Glucose with manufacture expiration date of 6/2023. During an observation and interview on 12/19/24 at 2:50 PM, License Practical Nurse(LPN) X unlocked the Pine Ridge Medication resident medication refrigerator, located in the medication room, with several resident medications as well as unlabeled frozen food in freezer and what appeared to be unlabeled drink in frig. LPN X reported resident medication frig should not have food or drinks stored in it and reported was unsure who put them there. LPN X verified only nurses have keys to medication rooms. LPN X unlocked Pine Ridge medication cart and verified Benadryl 25 mg had manufacture expiration date of 9/2024 and colace with manufacture expiration date of 11/2024. LPN X reported plan to discard both medications. During an interview on 12/20/24 at 10:10 AM, Director of Nursing(DON) B reported food should not be stored in resident medication refrigerator and medications should be discarded according to manufacture expiration dates. 45038 Resident #97 (R97) Review of the medical record revealed R97 was admitted to the facility 03/16/2023 with diagnoses that included dementia, heart disease, protein-calorie malnutrition, chronic obstructive pulmonary disease (COPD), hypertension, emphysema, anxiety, low back pain, scoliosis (spinal deformity), adjustment disorder, cognitive communication deficit, arthritis, peripheral vascular disease (PVD), Alzheimer's, cardiomegaly (enlarged heart), and hyperlipidemia (high fat content in blood). The most recent Minimum Data Set (MDS), with an Assessment Reference Date of 11/20/2024, revealed R97 had a Brief Interview for Mental Status (BIMS) of 07 (severe cognitive impairment) out of 15. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 12/17/2024 at 01:34 p.m. R97 was observed sitting up on the side of her bed. A medication cup was setting R97's over the bed table. Six pills were observed in the medication cup. Three of the pills were white, one pill was orange, and two pills were yellow. R97 could not explain what the pills in the medication cup were. When asked what the pills in the medication cup where, R97 responded ask them. When questioned who them were she responded Staff. In an interview on 12/18/2024 at 12: 55 p.m. Registered Nurse (RN) J explained that it was professional practice that medication was not to be left at the bedside of a resident. She explained that it was professional practice to observe the resident taking the medication that was provided by the nursing staff. In an interview on 12/19/2024 at 11:59 a.m. Director of Nursing (DON) B explained that residents could only self-administer medication if an assessment was completed by the interdisciplinary team and a physician order would be obtained. DON B explained that self-medication administration would be included in the resident's plan of care. DON B explained that it was the facility policy that the nurse providing the medication would witness the resident taking the medication. DON B confirmed that R97 did not have an assessment for self-medication administration. DON B also confirmed R97 did not have a physician order for self-medication administration. Review of facility policy entitled Medication by Licensed Personnel , most recent review date of 10/2024, revealed 12. Remain with the resident/patient until all mediation are taken

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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. 38905 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food in the kitchen. Findings include: During a tour of the kitchen, starting at 12:54 PM on 12/17/24, it was observed that a box of vegetables and large bag of potatoes were found stored on the floor of walk-in cooler three. An interview with Head Chef (HC) F found that deliveries come Monday and Thursday. During a tour of the walk-in freezer, at 1:42 PM on 12/17/24, it was observed that multiple boxes of food product were found stored on the floor such as vegetables and buttermilk biscuits. An interview with HC F found that the staff member who regularly puts product away has been off work. According to the 2022 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: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. During a tour of the kitchen, at 1:01 PM on 12/17/24, it was observed that black spotted debris accumulation was evident on the tops and side gaskets of the two door traulsen cooler. During an observation of clean utensil drawers, next to the stand-up mixer, at 1:05 PM on 12/17/24, it was observed that an accumulation of crumb debris was present inside of partitions and cubbies that help separate equipment. During an observation of the clean mechanical scoop drawers, at 1:35 PM on 12/17/24, it was observed that three white mechanical scoops were found with stuck on food debris in their inside portions and under the metal scoop slide. When asked if she could see the debris, HC F stated yes. Further review of the clean utensil drawer found an accumulation of crumb debris inside of the cubbies that help separate and organize the drawer. During a tour of the facility, at 1:39 PM on 12/17/24, an interview with HC F found that the meat slicer gets used weekly and is taken apart and cleaned after use. At this time observation of the meat slicer found a small amount of dried stuck on meat debris on the back side lip of the blade. Further observation found an accumulation of debris on the inside non-food contact portion of the slicer. Observations of the kitchenettes, starting at 2:14 PM on 12/17/24, found an increased accumulation of debris on the spouts of the ice machines in the following locations: Unit A, Pine, and Melody Trail. Ice spouts were found with a heavy accumulation of crusted white debris coating the inside spouts while the ice machine in Melody trail was found with a large white crusted growth around the inside spout of the machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 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. (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. During an interview with HC F, at 1:18 PM on 12/17/24, found that staff use the one compartment sink, next to the stand-up mixer, for food preparation. Observation of the sink found that it was directly connected to the wastewater drain. Observation of the three-compartment sink at 1:20 PM on 12/17/24, found that the sanitizer compartment of the sink did not have a visible air gap present to preclude against the contamination of wastewater backflow. Observation of the one compartment preparation sink, near the drink station, was found to be directly connected to the wastewater system. An interview with HC F, at 8:45 AM on 12/18/24, found that maintenance I believes that the air gaps for the preparation sinks and the three compartment sink are located in a crawl space below the kitchen. At 1:36 PM on 12/18/24, with Maintenance I, The surveyor went down into the crawl space below the kitchen and found that the preparation sink next to the stand up mixer and the three compartment sink were directly connected to the waste water system. Further observation found that the preparation sink next to the drink station contained an air break, where the drain had sunk down into the pipe no longer making a physical gap. According to the 2022 FDA Food Code section 5-402.11 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 . During an observation of the dry storage shelf, near the cook line, at 1:25 PM on 12/17/24, found an open gallon container of soy sauce with roughly a 1/4 of the product left. A review of the manufactures directions found it states to Refrigerate After Opening. According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of Unit A kitchenette, at 2:15 PM on 12/17/24, observation of the ice cart found a covered cooler half full of water with ice floating in it. When asked about how the ice coolers are taken care of, HC F stated that they get taken back to the kitchen each day to be cleaned between uses. There was no observation that found a way for the water to self drain from the cooler. Observation of the Pine kitchenette, at 2:34 PM on 12/17/24, found the ice chest half full with ice floating in water. Observation of the Unit A Kitchenette, at 9:43 AM on 12/18/24, found the ice chest only full of water. According to the 2022 FDA Food Code section 3-303.12 Storage or Display of Food in Contact with Water or Ice.(B) Except as specified in (C) and (D) of this section, unPACKAGED FOOD may not be stored in direct contact with undrained ice .

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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** 38905 Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During a tour of the facility, at 10:35 AM on 12/18/24, an interview with Maintenance (M) I found that Building Services Director (BSD) H handles the Water Management Plan (WMP). During a tour of Unit A soiled utility room, at 10:40 AM on 12/18/24, it was observed that water in the hopper was found to be low in the bowl. After flushing the hopper, the water in the bowl filled up with roughly two times the amount of water, indicating that the fixture is not regularly flushed to remove stagnation due to lack of use. During a tour of the Garden Grove janitors' closet, at 10:53 AM on 12/18/24, it was observed that a standard mop sink was present with no chemical dispense. When asked if this closet gets used very often, M I stated that housekeepers get chemicals from the main mop sink off the service hall and doesn't think staff use these hallway janitor sinks often. At this time, the surveyor turned on the hot and cold-water lines of the sink and found brown water momentarily come out until it turned clear. During a tour of the Victorian Lane janitors sink, at 11:09 AM on 12/18/24, it was observed that brown water momentarily came out of the faucet when the cold and hot water taps were turned on. During a tour of the Melody Trail janitors sink, at 11:23 AM on 12/18/24, it was observed that brown water momentarily came out of the faucet when the cold-water tap was turned on. During a tour of the Melody Trail soiled utility room, at 11:29 AM on 12/18/24, it was observed that water in the bowl the hopper was found very low and depleted, indicating a stagnant water line. Upon flushing the hopper, the water came back roughly two times the amount found in the bowl originally. During a tour of the Melody Trail spa room, at 11:32 AM on 12/18/24, it was observed that the room had a spa tub for use. An interview with M I found that the tub does not get used often. When asked if this was an area where staff are flushing water, M I was unsure. During a tour of the Harmony Way spa room, at 11:36 AM on 12/18/24, it was observed that the room had a spa tub for use. The tub was found dry and with bits of dust and debris inside of the tub basin. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with BSD H, at 2:32 PM on 12/18/24, found that some water fixtures in the facility are regularly flushed by staff, but the hoppers, janitor sinks, and spa tubs were not on a regular flushing schedule. When asked who was on the Water Management Team, BSD H stated that its mostly him. When asked if the facility samples water as part of the WMP, BSD H stated that he takes samples with a test strip that looks at multiple factors in the water. When asked what his control measures and limits are for the samples, BSD H was unsure and stated he uses the bottle as a gauge. A review of the test strips found that one of the indicators it tests for is total chlorine, when asked what residual he would look for regarding total chlorine, BSD H pointed to the test strip scale and stated 5 to 10 (parts per million). When asked if the facility has performed a risk assessment to identify where Legionella and other opportunist pathogens of premises plumbing could grow and spread, BSD H was unsure. A record review of facility provided documentation found no completed Centers for Disease Control (CDC) toolkit, and no reference to using the American Society of Heating Refrigeration and Air Conditioning Engineers (ASHRAE) Guidelines. A document entitled Water Management Program Team, dated [DATE], found members, including M I and BSD H. A review of the facility provided document entitled [NAME] County Health & Rehabilitation Services Policy and Procedure - Safe Water, revised 11/22, found that It is the Policy of [NAME] County Health & Rehabilitation Services to monitor drinking water for safety and have interventions in place when a concern arises. The document went on to state Housekeepers will turn on all showers, sinks as part of daily cleaning to ensure there is no stagnant water in pipes. Further review of the policy and procedure found that Water will be tested quarterly (more often if necessary) in house, using water testing kits. Testing sites will include 1 area from each section of the building. Findings will be documented on Quarterly Test Logs. A review of the facility provided Quarterly Water Test log, with most recent entries on 12/9/24, found no specified control limits to base results on. The log was also found with no values to indicate results, only a check mark and a line. No provided documentation was available describing control points, control measures, or control limits the facility has in place to reduce the risk of Legionella and other OPPP.