STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235036	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Rochester Hills Rehab & Nursing Ctr	1480 Walton Blvd Rochester Hills, MI 48309

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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	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** 38271 Based on interview and record review, the facility failed to ensure effective facility communication for honoring advanced directives for two residents (R48 and R315) of four residents reviewed for advanced directives. Findings include: On [DATE] at approximately 9:33 a.m., R48 was observed in their room, laying in their bed. R48 was observed to be thin and weak. On [DATE], R48's medical record was reviewed and revealed the following: R48 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Anxiety. R48's Code status (advanced directives) was documented as Full Resuscitate A facility document titled Advanced Directives/Medical Treatment Decisions revealed the following:I have chosen to formulate and issue the following Advanced Directives (checked) .Do Not Resuscitate (DNR) (checked) Further review of the document revealed it was signed by R48's POA (Power of attorney) on [DATE]. A facility document titled Do Not Resuscitate Order signed by R48's Physician and their POA on [DATE] revealed the following: Guardian consent .I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law. I acknowledge that I have attempted meaningful communication with the ward and the ward has either agreed to this Do-Not-Resuscitate Order or has not communicated any objection to this Do-Not-Resuscitate Order. I further acknowledge that I have discussed the ward's condition with the ward's attending physician and the Physician believes that a Do-Not-Resuscitate Order is appropriate for the ward . On [DATE] at approximately 9:57 a.m., Nurse D was queried what R48's advanced directive/code status was and they indicated that R48 was a full code and if their heart would stop then they would perform full resuscitation. Nurse D then was observed going into R48's medical record and reviewed the profile page that that indicated R48 was a full code and indicated again that they would perform CPR if they needed it. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 12:11 p.m., The Administrator was queried regarding the code status for R48 and the inconsistencies observed in the electronic medical record. The Administrator indicated that the Do Not Resuscitate Order form is used for documentation of wishes such as DNR and that it should match the profile page because that is what the Nurses utilize when checking code status. The Administrator was informed of the conversation with Nurse D and that the Nurse would have provided CPR to R48 if they needed it and they indicated that it was important for the document to match the profile page to ensure the residents wishes and directives are honored. 48680 R315 On [DATE] at 10:20 AM, R315 was observed lying in bed with a family member present. An interview was held with R315 and they were asked if it was okay to proceed with conversation with their loved one present and R315 stated, Yes, this is my guardian. R315 was then asked how the care was received at the facility. R315 stated that they were only at the facility for a short period of time because they were a hospice respite patient. A record review revealed that R315 was admitted to the facility on [DATE] with the diagnosis of shortness of breath, pain and disturbance of salivary secretion. A further review of the record revealed R315 was a full code status. On [DATE] at 11:02 AM, a conversation with the hospice nurse was held and she was asked what the code status was for R315. The hospice nurse replied, [R315] is a do not resuscitate (DNR). R315 asked for the question to be repeated and R315 was asked did they want to be resuscitated, R315 replied Oh, NO. On [DATE] at 3:00 PM, the Director of Nursing (DON) was interviewed and asked how the facility communicated with the hospice company for R315, the DON explained that they have been communicating verbally and that there is no actual book or log (used to communicate with hospice) at this moment. The DON was then questioned about R315's code status and if the facility was aware that resident wished to be a DNR. The DON replied that the resident was a full code on hospice according to the hospice company representative. The DON was informed that the Hospice Nurse and Resident both confirmed that R315 was to be a DNR. The DON stated she would have to investigate. On [DATE] at 3:13 PM an interview was held with R315 and was asked were they sure they wanted to be a DNR. R315, replied, Yes I'm sure, I believe I signed some papers to reflect my wishes, but you can bring me whatever paper it is that needs to be signed because I do not want to have CPR done. On [DATE] at 9:25 AM a review of the record revealed that R315 was still a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:32 AM a conversation was held with the Administrator and the [NAME] Clinical Nurse they were asked if they were made aware of R315 code status and that the resident would like to be considered a DNR. They explained that they spoke with the hospice representative when they came to the facility and told then that R315 was a full code. They were then asked if someone wanted to change their code status could they do so and who would be the team member to initiate those conversations with residents. The administrator replied, yes a code status could be changed at any time and the social worker would be the team member to see where person stood, however any nurse could have done so as well. She also stated that R315's hospice communication book was now available. A review of the hospice communication binder was obtained and within the communication book there was a signed DNR paper for R315 dated [DATE]. There was no additional information provided by exit of survey.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48680 Based on interview and record review, the facility failed to provide an Advance Beneficiary Notice (ABN) for three (R317, R318 and R54) of three residents reviewed and failed to provide Notice of Medicare Non-coverage (NONMC) for two (R317 and R318) of three residents reviewed. Findings include: A SNF (Skilled Nursing Facility) Beneficiary Notification Review form was completed by the State Agency representative and provided to the facility for residents R317, R318, and R57 to be filled out by facility staff and returned for notification review. On 8/28/24 at 10:00 AM, the administrator indicated that they were unable to find any of the ABN's and NONMC's for the residents that were requested. There was no additional information provided by the exit of the survey.

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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** 38271 Based on interview and record review, the facility failed to report an allegation of abuse to the State Agency for one resident (R11) of two residents reviewed for abuse/neglect/mistreatment. Findings include: On 8/26/24 the medical record for R11 was reviewed and revealed the following: R11 was initially admitted on [DATE] and had diagnoses including Psychotic disorder with delusions, Anxiety and Dementia. A review of R11's progress notes revealed the following: 7/9/2024 .Nurses' Notes: Heard loud commotion from the dining room. Entered dining room to see [R11] standing over another resident (R37) pouring coffee and grabbing at her. Residents were separated. Assessed resident that the coffee was poured onto for any injuries. Abrasion to right side cheek. and discoloration to lower right arm. Notified both family party. Notified unit nurse. Notified administrator. Notified MD (Medical Doctor). On 8/28/24 at approximately 1:55 p.m., Nurse E was queried regarding their progress note and the incident with R11 pouring coffee on R37 and grabbing her. Nurse E indicated they walked into the dining room and R11 was standing over R37 and grabbing them. Nurse E indicated that R37 had coffee poured all down the side of them and that another resident had observed the whole incident and had informed them that R11 had poured coffee on R37 and was fighting them. On 8/27/24 at approximately 3:20 p.m., the medical record for R11 was reviewed with the Administrator and they were queried if the facility had reported the allegation and they indicated that it was not reported and they did not have any information on the incident. The Administrator was queried if the allegation should have been reported to the State Agency and investigated they indicated that it should have. On 8/27/24 a review of the facility reported incidents in the State Agency's electronic system was conducted which did not reveal the incident had been reported to the State Agency. On 8/28/24 at approximately 2:20 p.m., the Administrator followed up with additional information pertaining to the allegation but indicated they do not have any documentation that it was reported to the State Agency for review. On 8/28/24 a facility document titled Abuse and Neglect was reviewed and revealed the following: POLICY: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guidelines include compliance with the seven (7) federal components of prevention and investigation Reporting/Response: Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator ' s Designee. All allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received

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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** 38271 Based on interview and record review, the facility failed to ensure a thorough investigation into allegations of abuse were completed for two residents (R11 and R25) of two residents reviewed for abuse/neglect/mistreatment. Findings include: R11 On 8/26/24 the medical record for R11 was reviewed and revealed the following: R11 was initially admitted on [DATE] and had diagnoses including Psychotic disorder with delusions, Anxiety and Dementia. A review of R11's progress notes revealed the following: 7/9/2024 .Nurses' Notes: Heard loud commotion from the dining room. Entered dining room to see [R11] standing over another resident (R37) pouring coffee and grabbing at her. Residents were separated. Assessed resident that the coffee was poured onto for any injuries. Abrasion to right side cheek. and discoloration to lower right arm. Notified both family party. Notified unit nurse. Notified administrator. Notified MD (Medical Doctor). 5/27/2024 .Nurses' Notes: Resident reported abuse by roommate .writer reported to Administrator and DON (Director of Nursing) .filled out incident report. 5/15/2024 .Nurses' Notes: when this resident try to enter other resident room other resident stopped this resident with her arm. When stop this resident grabbed other resident face and scratched it . Administrator aware. Son aware. On 8/27/24 at approximately 3:20 p.m., the medical record for R11 was reviewed with the Administrator and they were queried if the facility had reported the allegations for July and May 2024 in the record and they indicated that it was not reported and they did not have any information on the incidents and that they were a new Administrator to the facility and had recently started in August 2024. The Administrator was queried if the allegations should have been reported to the State Agency and investigated they indicated that it should have. On 8/27/24 a review of the facility reported incidents in the State Agency's electronic system was conducted which did not reveal the incidents had been investigated and reported to the State Agency. On 8/28/24 at approximately 1:55 p.m., Nurse E was queried regarding their progress note and the incident with R11 pouring coffee on R37 and grabbing her. Nurse E indicated they walked into the dining room and R11 was standing over R37 and grabbing them. Nurse E indicated that R37 had coffee poured all down the side of them and that another resident had observed the whole incident and had informed them that R11 had poured coffee on R37 and was fighting them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at approximately 2:20 p.m., The Administrator followed up with additional information pertaining to the allegation on 7/9/24 and provided pieces of the medical record for R11 and R35 for the incident. No investigative summary/conclusion or witness statements pertaining to the incident were provided. The Administrator indicated they did not have any information or investigations for the other allegations noted in R11's record on 5/27 and 5/15. 41415 R25 On 8/26/27 at 9:48 AM, R25 was observed laying down in their bed with their head slightly elevated sleeping with milk in their hand. R25's breakfast tray was observed uneaten in front of them. R25 was easily awaken with verbal stimuli. Once awake R25 did not respond to any questions, however continued to sip their milk. Review of the medical record revealed R25 was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease and senile degeneration of the brain. A Brief Interview for Mental Status (BIMS) score dated 6/17/24 documented a score of 7, which indicated severely impaired cognition. R25 required staff assistance for most Activities of Daily Living (ADLs). Review of a progress note dated 3/1/24 at 1:34 PM, documented in part . CNA (Certified Nursing Assistant) & hall monitor came to writer to advise that residents left eye was bruised swollen and a cut on the side of left eye. Writer had wound care nurse look at resident. Cut is deep, wound care nurse cleaned cut and put A&D ointment on resident . Dr (doctor) contacted and DON (director of nursing) Unit manager contacted. Sending to ER (emergency room) for possible stitches by non emergent services . Review of the medical record revealed no hospital records on file. The Administrator and Director of Nursing was asked to provide the hospital documents from the 3/1/24 ER visit and no documents were provided by the end of the survey. Review of a facility incident report dated 3/1/24 at 8:45 AM, documented in part . CNA & hall monitor came to writer to advise that residents left eye was bruised swollen and had a cut on the side of the left eye . Patient unable to give description . Left eye bruised (Black eye), Left side of eye laceration about an inch long and deep, Middle between eyes bruised, Left eye pink . Review of a Physician note dated 3/1/24 at 11:21 PM, documented in part . I was asked to evaluate patient because this morning she was found to have bruises and scratches around her left eye and left cheek, patient could not tell how it happened, she denied any fall, she denied any pain, her neuro examination is normal, she does not appear in any distress. I tried with patient to know what is happening, she denied fall, she denied any trauma, she denied any abuse by any other patient or staff she denied any present and she could not recall how it happened . Likely traumatic and possible fall . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/21 at 3:15 PM, the Administrator who also serves as the facility's Abuse coordinator was interviewed and asked if the injury of unknown origin was reported to the State Agency (SA), the Administrator stated they did not believe so. The Administrator was recently hired at the facility and was not the Administrator at the time of the incident. The Administrator stated they would follow up to see if a soft file and/or investigation was completed for this incident. The Administrator provided the number to the Previous Administrator (PA) B who was the Administrator at the facility on 3/1/24. On 8/27/24 at 4:14 PM, PA B was interviewed via telephone and asked about the incident with R25 on 3/1/24. PA B stated they were going to look up their notes in the system. PA B read the progress notes and incident report and stated they did not remember any of their staff members informing them of the incident. PA B stated had they known, they would have immediately started an investigation, informed their corporate staff and reported the incident to the State. Review of the facility policy titled Abuse and Neglect revised 6/17/19, documented in part . Investigate all allegations of abuse, neglect, misappropriation or property and incidents such as injuries of unknown source. All allegations will be investigated by the Administrator or Designee immediately . The facility failed to conduct an investigation for R25's injury of unknown origin. No further explanation or documentation was provided by the end of the survey.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record reviews the facility failed to ensure a Level II screening was completed for one resident (R54) of four residents reviewed for PASAR (PAS - Preadmission Screening - ARR - Annual Resident Review). Findings include: On 8/26/24 at 9:44 AM, R54 was observed walking the unit hallways. R54 asked the surveyor multiple times if they wanted to hug. An interview was conducted with R54 at that time. A review of the medical record revealed R54 was admitted to the facility on [DATE] with diagnoses that included epilepsy and dementia. Review of a level I Screening dated 2/16/24, documented a Hospital Exemption Discharge . Mental Illness . The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days . Review of a Level II Screening dated 2/16/24, documented in part Hospital Exempted Discharge . is being admitted after a hospital stay . requires nursing facility services for the condition for which he/she received hospital care . is likely to require less than 30 days of nursing services . R54 remained in the facility more than the 30-day exemption criteria and the facility did not submit a level II screening to be completed. On 8/27/24 the Administrator was asked to have the facility's Social Worker (SW) present for an interview. At approximately 10:30 AM, the Administrator stated they were currently assisting in the role as the SW until the new SW began employment. The Administrator was asked about R54's initial hospital exemption screening and why after the 30 days of being at the facility had they not submitted another Level I or II for R54. The Administrator explained they were recently hired at the facility, since the new ownership change thirty days prior, but would look into it and follow back up. At 11:36 AM, the Administrator stated R54 should have had another screening completed. The Administrator stated they identified guardianship issues and concerns initially since the start of their employment which was their focus, however, will also add PASARR screenings to their list.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41415 Based on observation, interview and record review the facility failed to implement adequate care plan interventions for a language barrier/communication problem for one (R3) of 16 sampled residents reviewed for care plans. Findings include: R3 On 8/26/24 at 9:59 AM, R3 was observed sitting in their wheelchair with a head wrap on. An interview was attempted however unsuccessful. R3 was identified to only speak Arabic. Certified Nursing Assistant (CNA) K confirmed that R3 only speaks in Arabic. CNA K who stated they were R3's assigned CNA for the day, was asked how they communicated with R3 and CNA K stated they used an activities aide who speaks Arabic or the resident's family. CNA K was asked to have the activities aide assist in translating for the surveyor and CNA K stated the activities aide was off duty this day. Review of a care plan titled I am at risk for impaired communication related to cognitive impairment, As evidenced by: difficulty making self-understood, As evidenced by: difficulty understanding others, As evidenced by: language barrier; English is not resident's primary language created on 8/30/23. The complete list of documented interventions were . Allow ample time for the resident to comprehend what is being communicated and allow time for response . Anticipate and meet the resident's needs . Encourage conversations in calm, quiet locations with minimal background noise . Maintain eye contact, approach resident from the front . Observe for physical/non-verbal indicators of discomfort or distress and follow-up as needed . Pay attention to resident's body language and facial expressions . Provide translator as needed to communicate with the resident. Translator is (Family or activities aide) . SLP (speech language pathologist) screen/ eval (evaluation) / treat as needed . Use simple and direct communication (i.e., yes/no questions) to promote understanding, use gestures or pictures if necessary . On 8/27/24 at 9:42 AM, the Administrator was interviewed and asked what resources the facility had for staff to communicate with residents whose first language was not English or was unable to understand English. The Administrator stated they had an interpreter hotline that will accommodate various languages. The Administrator was then asked why the intervention of the hotline number and protocol was not implemented in R3's care plan and why CNA K had no knowledge of the interpreter hotline and the Administrator stated they would start education with staff today. A policy was requested at this time. A policy was not provided by the end of the surveyor, however the Administrator did return at 11:35 AM and stated the facility also had a flip guide in Arabic and will update R3's care plans and educate the staff.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 48680 This citation pertains to Intake #MI00145963 Based on interview and record review the facility failed to facilitate a safe and coordinated discharge for one resident (R312) out of three reviewed for discharge. Findings include: A complaint was submitted to the State Agency with the allegations of an improper discharge of a trach and peg tube resident into the community with no home health care or adequate nutrition for the resident's needs. On 8/28/24 at 1:12 PM the Director of Nursing (DON) was interviewed and asked who was in charge of the discharge planning process and what home health agency was used for R312. The DON explained that in most cases the discharging of residents usually goes through the interdisciplinary team (IDT) and is discussed what a resident will need, the community tools and any additional medical providers may need to conduct a safe discharge. However, at that time, the facility did not have a social worker to help facilitate outside agencies effectively. Upon further discussion, it was expressed to the DON that there was no discharge progress note nor a Home Health Care agency ordered in the medical record for R312. The DON replied, I can get the number of the agency used. On 8/28/24 at 1:39 PM an interview was held with the Home Health Care(HHC)agency provided by the DON. The HHC representative was asked if R312 was on their case load, the HHC replied, No, [R312] was not on the case load due to difficulty with insurance coverage, and we communicated that with the facility that we were unable to accept them at this time. There was no additional information provided by the exit of survey.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation has two deficient practice statements (DPS). DPS #1 Based on observation, interview, and record review, the facility failed to coordinate follow up cardiology, pulmonology, and gastrointestinal (GI) appointments for two (R57 and R58) of two residents reviewed for appointments. Findings include: Resident #57 (R57) On 8/26/24 at 10:00 AM, R57 was observed lying in bed. During an interview, R57 presented with pursed breathing and appeared uncomfortable. When queried, R57 reported he had trouble breathing when he was worked up. R57 was receiving three liters of oxygen via nasal cannula at that time. R57 reported he recently went to the hospital for his breathing and he was supposed to follow up with a doctor so he could find out what was going on. R57 reported the facility has not assisted with making that follow up appointment. On 8/26/24 at 3:53 PM, R57 was observed lying in bed. When asked how he was doing, R57 stated, Not well. When queried about what was wrong, R57 reported he was having trouble breathing and was observed with pursed breathing. At that time, Licensed Practical Nurse (LPN) 'A' took R57's vital signs which were within normal limits. R57 was administered his physician ordered albuterol inhaler. R57 told LPN 'A' that he was feeling like he always feels. A review of R57's clinical record revealed R57 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: chronic obstructive pulmonary disease (COPD), history of pneumonia, and anxiety disorder. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R57 had intact cognition and received oxygen therapy. A review of R57's progress notes revealed the following: On 7/25/24, it was documented R57 was sent to the hospital per his request due to shortness of breath. His oxygen level was 95 percent via nasal cannula. On 7/29/24, R57 was readmitted into the facility with wheezing sounds both lungs upon auscultation. A review of R57's Patient Discharge Instructions dated 7/29/24 revealed the following: Discharge Diagnosis: COPD exacerbation; Hypoxia (low oxygen) .Follow-up Instructions .cardiology, follow up for outpatient stress test .within 1 week .pulmonary .within 1 to 2 weeks . Further review of R57's progress notes revealed the following documentation: On 8/15/24, it was documented R57 refused a shower because I get really short of breath and it's too hard for me. (continued on next page)

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	235036	A. Building B. Wing	08/28/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24, it was documented R57 refused a shower and stated, I don't wanna take a shower today. I'm tired and get short of breath when I moved <sic> around. On 8/26/24, it was documented R57 reported shortness of breath on three liters of oxygen. On 8/27/24 at 11:40 AM, an interview with the Director of Nursing (DON) was conducted. When queried about whether R57 had the cardiology and pulmonary follow-up appointments as documented on the hospital discharge instructions, the DON reported she would look into it. On 8/27/24 at 12:45 PM, the DON followed up and reported the MDS nurse was responsible for making the appointments. The DON reported the MDS nurse said she was going to make the appointments but the physician did not want R57 to see the cardiologist or pulmonologist. A review of R57's progress notes revealed no evaluation by the physician since readmission into the facility on [DATE] and no documentation of a medical justification for not following through with the cardiologist and pulmonologist. The DON confirmed there was no documentation. Resident #58 (R58) On 8/26/24 at 10:34 AM, R58 was observed positioned on his back in bed with a tracheostomy tube (a tube inserted into the windpipe to provide breathing assistance) and a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to directly provide nutrition). When spoken to, R58 did not make eye contact and did not verbally respond to questions. A review of R58's clinical record revealed R58 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: diffuse traumatic brain injury with loss of consciousness, acute respiratory failure with hypoxia, type 2 diabetes, and seizures. A review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed R58 had severely impaired cognition, was dependent on staff all activities of daily living, received all nutrition via a PEG tube, and had a tracheostomy tube to assist with breathing. A review of R58's progress notes revealed the following documentation on 7/20/24, Writer heard resident coughing and upon entering the room assessed that resident had vomited a large amount amount of reddish-brown emesis coming out of mouth and trach continued to vomit large amounts and writer noted resident also had loose stools and respirations became elevated .Writer called doctor advised to be sent to ER (emergency room). A review of R58's Clinical Discharge Instructions from the hospital on 7/23/24 revealed, .Discharge Diagnosis: .aspiration of vomit; Aspiration pneumonia; Sepsis .Instructions .Follow up .GI follow up .Within 1 to 2 weeks . On 8/28/24 at 8:54 AM, an interview was conducted with the DON. When queried about whether R58 had the GI follow up appointment that was documented in the hospital discharge instructions, the DON reported she would look into it. On 8/28/24 at 1:35 PM, the DON followed up and reported an appointment was not made for R58 to have a GI consult. 48680 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DPS #2 Based on observations, interviews and record reviews the facility failed to properly transcribe hospital discharge orders for one(R316) of five residents reviewed for medication orders. Findings include: On 8/26/24 at 10:00 AM an observation of R316's room was made. There was a contact isolation cart located inside of the room. R316 was at dialysis and the curtain was opened in room. A record review revealed that R316 was admitted to the facility on [DATE] with the diagnoses of pneumonia, hypertension and end stage renal disease. On 8/27/24 at 8:32 AM, R316 was observed lying in the bed reading some papers. An interview was conducted. R316 was asked about their current stay at the facility, R316 replied, It is a pretty decent facility, but the wait times are a bit excessive in my opinion. R316 was asked could they recall why they were put in contact isolation. R316 stated, No, whatever I had was at the hospital and it was in my coccyx wound. On 8/27/24 at 9:10 AM, the facility's Infection control preventionist (ICP) was interviewed and asked the reason R316 was placed in contact isolation, what changed in R316 diagnosis from 8/26/24 to 8/27/24 since taken off contact precautions and, lastly, why a contact isolation cart was placed inside of room instead of outside of the room. The ICP explained R316 was placed on isolation because of the diagnosis from the hospital, however when the hospital paperwork was reviewed, it was found that R316 had completed their round of antibiotics and no longer needed isolation so precautions were discontinued. The ICP further stated, The reason I was able to place the isolation cart in the room as opposed to the outside of the room was because there is a curtain in the room, and we use that for a barrier. A review of the medical record revealed that R316's hospital paperwork did not mention being in contact isolation, there was an antibiotic ordered with an incorrect indication for use as well as a total of three medications transcribed improperly from the hospital discharge to the current medication list. On 8/27/24 at 12:08 PM, an interview was conducted with the Unit Manager(UM), Director of Nursing(DON), and the ICP. They were asked when there is a new admission, what was the protocol for the facility when placing orders, and what paper from the hospital did they use to get medication orders from. The DON replied, We are supposed to call the medical doctor(MD), read the orders from the hospital paper work and the MD decides whether they want to continue with treatment or not. We are supposed to use the hospital discharge paper work or the after visit summary to transcribe orders. A review of the hospital paper work was made with the DON, UM and ICP. They were asked how did they get the orders for R316 for their Entresto and Dicyclomine when the hospital after visit summary stated to discontinue and start amiodarone which there were no current active orders for amiodarone in the medication administration record(MAR) for R316. The DON replied, We would have to call the MD to verify (the medication discrepancies). The DON explained that medication clarification should be done upon admission and the orders should reflect the hospital discharge paperwork. No addition information was presented by the exit of the survey.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record review the facility failed to follow up on the audiology recommendations and services timely for one R7 of one resident reviewed for audiology services. Findings include: On 8/26/24 at 9:31 AM, R7 was observed lying in bed reading a book. An interview was attempted, however the resident stated they were hard of hearing. The surveyor then questioned the resident up close to their left ear and the resident was able to proceed with the interview. R7 explained they tried getting hearing aides at the facility but no one would direct them on who to talk to or where to go. A review of the medical record revealed R7 was admitted to the facility in 2016, with diagnoses that included major depressive disorder and Parkinson's disease. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Review of the medical record revealed no consultations of an audiology assessment and/or examination. Multiple physician notes documented hard of hearing. On 8/27/24 at 9:45 AM, the Administrator (who was also assisting with the Social Worker - SW duties) was interviewed and asked about any completed audiology examinations for R7. The Administrator stated they would check into it and follow back up. At 11:52 AM, the Administrator stated they were unable to find documentation of an audiology appointment for R7 in their medical record. The Administrator stated they called the audiology group utilized by the facility and they stated R7 was seen in the past and would send over the consultation. Review of an audiology consult dated 2/7/24, documented in part . Complains of tinnitus (ringing in ears). Family/staff notices recent decreased responsiveness . Moderate to Severe Sensorineural Hearing Loss - Both Ears . Was needs removal - Right (ear) . Medical Consult due to: To obtain medical clearance for aid(s); Wax Removal - Right Ear . Patient in need of wax removal; Medical Consult to obtain medical clearance for Hearing Aid . Review of the medical record revealed no follow up was completed per the audiologist recommendations. Review of the care plans revealed no identification of the audiologist recommendations or concerns. On 8/28/24 at 8:54 AM, the Director of Nursing (DON) was interviewed and R7's audiology consult was reviewed. The DON was asked about the lack of follow-up regarding the audiologist recommendations and the DON explained they were recently hired at the facility and acknowledged the concerns. The DON stated R7 has been added to the audiology list and should be seen today (8/28/24). No further explanation or documentation was provided before the end of the survey.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to prevent the development and worsening of facility acquired pressure ulcers for two (R58 and R22) of two residents reviewed for pressure ulcers and failed to implement treatments in a timely manner (R58 and R22) and according to physicians orders (R58 and R22), ensure assessments of wounds were accurate (R58 and R22), and ensure oversight by a medical provider after the development of a pressure ulcer (R58), resulting in R58 developing a stage II pressure ulcer (partial-thickness skin loss with exposed dermis) that developed into a Stage IV pressure ulcer (Full-thickness skin loss) with acute osteomyelitis (bone infection) and R22 developing an unstageable pressure ulcer (Obscured full-thickness skin and tissue loss). Findings include: Resident #58 (R58) On 8/26/24 at 10:34 AM, R58 was observed positioned on his back in bed with his neck tilted to the right side with a tracheostomy tube (a tube inserted into the windpipe to provide breathing assistance) and a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to directly provide nutrition). When spoken to, R58 did not make eye contact and did not verbally respond to questions. On 8/26/24 at approximately 1:15 AM and 4:00 PM, R58 remained positioned on his back with his neck tilted to the right side. On 8/27/24 at 8:02 AM, 9:40 AM, and 10:32 AM, R58 was positioned on his back with his neck tilted to the right side. At 10:32 AM, Certified Nursing Assistant (CNA) 'H' entered R58's room to provide care. When CNA 'H' exited R58's room, he reported he cleaned R58 up and repositioned him. Upon observation at 11:01 AM, R58 remained positioned on his back the same as previous observations. On 8/27/24 at 4:43 PM and 8/28/24 at 8:04 AM, R58 was observed positioned on his back with his neck tilted to the right side. During all of the above observations, it appeared there were pillows underneath R58's knees and heel protectors on his feet, but no positioning devices were observed to off load pressure from the buttocks. A review of R58's clinical record revealed R58 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: diffuse traumatic brain injury with loss of consciousness, acute respiratory failure with hypoxia, type 2 diabetes, and seizures. A review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed R58 had severely impaired cognition, was dependent on staff for transfers, toileting hygiene, bed mobility, and did not walk. The MDS assessment indicated R58 did not have any pressure ulcers at the time of the assessment. A review of a History and Physical from a hospital admitted d 7/20/24 (the day R58 was transferred to the hospital from the facility) revealed, .CT (Computed Tomography) abdomen pelvis showed gluteal region decubitis ulcers to the left of the midline with an open wound and multiple gas locules extending deep to the coccyx (tailbone) with concern for osteomyelitis . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of an Infectious Disease progress note dated 7/22/24 revealed, Impression and Plan .Septic shock secondary stage 4 sacral decubitis infection complicated with Proteus bacteremia . A review of Clinical Discharge Instructions from the hospital provided to the facility dated 7/23/24 revealed, . Discharge Diagnosis: Acute osteomyelitis .Sepsis .Plan of Care .Wound Care by nursing Start dt(date)/tm(time): 7/22/24 .DAILY - Irrigate sacral buttock wound with Dakins solution in a 10 ml (milliliter) syringe til clear. Then soak a 4x4 gauze in Dakins solution and wring it out, open it up and pack it into the wound undermining space. Cover with dry 4x4s, ABD (abdominal pad), secure with tape . Further review of R58's clinical record revealed the following: A review of a Nursing Admission Evaluation dated 6/11/24 revealed no documentation of any skin impairments to R58's sacrum or buttocks. A review of a Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] revealed R58 was at high risk for pressure ulcers based on a score of 11 (High Risk is between 10 and 12). A Skin assessment dated [DATE] revealed new abnormal skin areas to the left buttock and treatment was initiated. It was documented that wound care nurse aware. Stating that its MASD (moisture associated skin damage). There was no documentation of a full assessment of the wound on 7/2/24. A review of a Nurses' Note dated 7/3/24 revealed, .informed of Left buttock skin changes . A review of a Skin & Wound Evaluation dated 7/4/24 (two days after new abnormal skin areas to R58's left buttock were identified on the skin assessment) revealed R58 had a Stage 2 pressure ulcer to the right ischial tuberosity that was in-house acquired as of 7/3/24. It was documented that the pressure ulcer was staged by the in-house nurse and measured 7.7 centimeters (cm) in length by 3.8 cm in width with a depth of 0.1 cm. It was documented the wound was healable and that the medical practitioner (Physician 'K') was notified. It should be noted that the skin assessment dated [DATE] and the nurses' note dated 7/3/24 documented a skin impairment to R58's left side, not the right side. A review of R58's Physicians Orders and Treatment Administration Record (TAR) for July 2024 revealed an order to apply triad (a hydrophilic wound dressing) to the left ischium and to cover with bordered foam every night shift beginning on 7/4/24 and it was discontinued on 7/16/24. (It should be noted that it was documented on the Skin & Wound Evaluation that R58 had a Stage 2 pressure ulcer to the right ischial tuberosity.) A review of a Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE] revealed R58 was assessed as very high risk for developing pressure ulcers, as evidenced by a score of six (a score of nine or below indicated very high risk). A review of a Nurses' Note dated 7/9/24 revealed, Resident seen by wound care r/t (related to) stage 2 on right ischium (hip bone). Upon most recent assessment wound was smaller, but wound bed contained slough and was slightly deeper and has now been changed to stage 3 (Full-thickness skin loss). Tx (treatment) changed to medihoney and calcium alginate with bordered foam dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of a Skin & Wound assessment dated [DATE] revealed R58 had a Stage 3 pressure ulcer to the right ischial tuberosity that was identified on 7/3/24 and measured 6.6 cm by 4.0 cm. It was documented depth was not applicable and 40 percent of the wound by filled with slough (a non-viable yellow, tan, grey, green or brown tissue that is usually moist and can be soft, stringy and mucinous in texture). It was documented the treatment was changed to medihoney and calcium alginate with bordered foam dressing. The assessment noted the practitioner was notified, but did not document the name of the provider. A review of R58's Physicians Orders and TAR for July 2024 revealed no change in treatment order until 7/16/24, seven days after it was documented the pressure ulcer worsened from a Stage 2 to a Stage 3 and there was to be a change in treatment. There was no order for treatment to the right ischium which was the location that was documented on the Skin & Wound assessment. The treatment implemented on 7/4/24 for the stage 2 pressure ulcer remained in place until 7/15/24. On 7/10/24 and 7/15/24, the physician ordered treatment was not administered as evidenced by no nurses' signature on the TAR. The treatment was changed on 7/16/24 to Honey gel followed by calcium .to left ischium .cover with bordered foam dressing . and was discontinued on 7/21/24 after R58 was transferred to the hospital. A review of a Skin & Wound Evaluation dated 7/18/24 revealed R58 had an unstageable pressure ulcer to the left ischial tuberosity that was in-house acquired since 7/3/24. The wound was staged by in-house nursing and measured 6.0 cm by 4.5 cm. The wound was 90 percent filled with slough and therefore the depth of the wound was unable to be determined. It was documented the wound was healable and the treatment was not changed at that time. It was documented Physician 'K' was notified. A review of a second Skin & Wound Evaluation dated 7/18/24 revealed R58 had a Stage 2 pressure ulcer to the right ischial tuberosity that was in-house acquired that measured 0.7 cm x 0.4 cm. Treatment included zinc barrier cream and bordered gauze dressing which, according to physicians orders, was ordered on 7/18/24 and discontinued on 7/20/24. A Skin & Wound Evaluation dated 7/25/24 noted the pressure ulcer to the right ischial tuberosity was resolved on that date. A review of R58's TAR for July 2024 revealed an order to check placement of right ischial dressing started on 7/6/24 and discontinued on 7/15/24 and an order to check the placement of left ischial dressing started on 7/16/24 and discontinued on 7/21/24. Further review of R58's progress notes revealed R58 was transferred to the hospital on 7/20/24. A review of a Nursing Admission Evaluation dated 7/23/24 (upon readmission from the hospital) revealed R58 had a pressure ulcer to the coccyx. A review of a Skin & Wound Evaluation dated 7/25/24 revealed R58 had a Stage 4 pressure ulcer to the left ischial tuberosity, present since 7/3/24 (it should be noted that it was previously assessed to be on the right side) that measured 5.6 cm x 3.8 cm with 3.8 cm of undermining (the destruction of tissue or ulceration extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface). It was noted the would was 80 percent filled with slough with heavy exudate (drainage). There was no documentation of treatment and it was noted that the practitioner was notified. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of R58's Physician's Orders and TAR for July 2024 revealed no treatment order was put in place for R58 until 7/25/24, two days after he was readmitted into the facility with a diagnosis of acute osteomyelitis. On 7/25/24, the treatment ordered was Cleanse with wound cleanser. Pat dry. Apply Honey Gel as directed to left ischium and pack wound with calcium alginate. Skin barrier wipe to peri wound. Cover with bordered foam dressing. Every night shift for wound care. This order remained in place until it was discontinued on 8/12/24. The treatment was not done on 7/28/24, 7/29/24, and 7/31/24. It should be noted that this was not the same order documented in the hospital discharge instructions/plan of care that noted, Irrigate sacral buttock wound with Dakins solution in a 10 ml syringe til clear. Then soak a 4x4 gauze in Dakins solution and wring it out, open it up and pack it into the wound undermining space. Cover with dry 4x4s, ABD, secure with tape. A review of all progress notes for R58 revealed R58 was seen by a physician 'I'on 6/20/24 for a competency evaluation and on 6/26/24 for a History and Physical. There was no documentation in the electronic medical record that indicated R58 was evaluated by a medical practitioner after 6/26/24 and not after the development of a pressure ulcer that continued to worsen from a Stage 2 to a Stage 3/Unstageable and then a Stage 4 pressure ulcer on the day R58 arrived at the hospital. The next time R58 was evaluated by a medical provider was on 8/13/24 when he was seen by the wound physician. On 8/27/24 at 3:01 PM, an observation of R58's pressure ulcer was made with Licensed Practical Nurse (LPN) 'L' who was the Wound Care Coordinator for the facility. The wound was observed to be on the left buttock area, approximately nickel sized, packed with gauze with an undetermined depth. On 8/28/24 at 8:54 AM, an interview was conducted with the Director of Nursing (DON). When queried about whether residents with pressure ulcers received evaluations by a medical provider, the DON reported the facility had an issue with some of the physicians seeing residents in a timely manner. When queried about whether the facility contracted with a wound provider, the DON reported the facility hired a wound physician on 8/1/24 and he started seeing residents on 8/13/24. The DON explained that Licensed Practical Nurse (LPN) 'L' was the Wound Care Coordinator for the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/28/24 at 9:20 AM, an interview was conducted with LPN 'L' who reported she was wound care certified. When queried about her role, LPN 'L' reported she rounded with the wound care provider weekly, but if there was no wound care provider, she would still assess the wounds. When queried about the facility's protocol when a new skin impairment was identified, LPN 'L' explained the nurse wrote it on the wound care log or told LPN 'L' in person and the nurse would start a treatment. LPN 'L' further explained that when she was at the facility she would assess the wound and ensure the proper treatment was in place. When queried about any new interventions that were put in place for R58 after he developed a pressure ulcer to the left ischium, LPN 'L' reported she would look into it. At that time, it was requested that LPN 'L' provide information about what interventions were put into place on 7/2/24 when R58 was first identified to have skin impairment to the left buttock, on 7/4/24 when it worsened to a Stage 2, on 7/11/24 when it worsened to a stage 3, and on 7/18/24 when it was identified as an unstageable pressure ulcer. LPN 'L' reported she would look into it. When queried about the confusion about what side of R58's body the worsening pressure ulcer was, LPN 'L' reported it was her mistake and the existing pressure ulcer present on the left ischium was also the first one that developed on 7/4/24 and she did not document the correct side in her assessment. When queried about how R58 should be repositioned due to his lack of mobility and tracheostomy status, LPN 'L' said it was hard to reposition him on his side due to the trach, but he should be repositioned with devices to off load pressure. When queried about how residents were monitored to ensure interventions were implemented according to the residents' plan of care, LPN 'L' reported nurses were responsible to monitor the CNAs and LPN 'L' will make observations as well. When queried about whether R58 was evaluated by a medical provider related to the pressure ulcer, LPN 'L' reported he was seen for the first time in the past couple weeks because the facility did not have a wound provider. LPN 'L' was not sure if R58's wounds were evaluated by an attending physician in the absence of a wound provider. LPN 'L' reported she notified the attending physician by writing it in a log if a new wound has developed or it worsened and that it was also discussed during the daily interdisciplinary team meetings. On 8/28/24 at 11:25 AM, the DON and LPN 'L' reported they did not see any additional interventions implemented for R58 after the development of the pressure ulcer to the left ischium. They also confirmed there was no documented evaluation by a medical provider until 8/13/24 which was after R58 developed a stage 2 that worsened to a stage 4 with osteomyelitis. When queried about the treatments not being implemented timely after each worsening stage of the wound, no explanation was given. Resident #22 (R22) On 8/26/24 at 12:04 PM, an interview was conducted with R22's family member who revealed a concern that the facility was keeping R22 up in the wheelchair for too long which resulted in a healed pressure ulcer reopening. R22's family member reported there were physicians orders to keep her out of the chair but staff are inconsistent with following the orders. On 8/27/24 at 8:01 AM, R22 was observed seated in a geriatric chair (reclined chair) in her room. At 9:39 AM, 10:34 AM, 12:57 PM, and 1:30 PM, R22 remained seated in the chair for a total of five and a half hours. A review of R22's clinical record revealed R22 was admitted on [DATE] with dementia and type 2 diabetes and signed onto hospice on 4/27/24. A review of R22's MDS assessment dated [DATE] revealed R22 had severely impaired cognition, was dependent for transfers, required substantial/maximal assistance for bed mobility, was incontinent of urine and stool, and had no unhealed pressure ulcers. (continued on next page)

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	235036	A. Building B. Wing	08/28/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R22's Physicians Orders revealed an active order started on 8/22/24 that read, Resident to be assisted to bed between meals every shift for wound prevention. A review R22's TAR for August 2024 revealed the order was not carried out on on all shifts on 8/23/24, 8/24/24, and 8/25/24; and it was not done on 8/27/24 during the day shift. A review of a Skin Observation Tool dated 8/17/24 revealed no documentation of a skin alteration to R22's sacrum or coccyx. A review of a Skin Observation Tool dated 8/23/24 revealed R22 had a new alteration in skin integrity which was documented as a small wound to the coccyx. Prior to that date there were no new skin alterations documented on the weekly skin observation tools. A review of a Skin & Wound Evaluation dated 8/20/24 revealed R22 had a new unstageable pressure ulcer to the sacrum that was 14 days old and measured 5.55 cm by 3.24 cm with 100 percent slough tissue. A review of R22's progress notes revealed no documentation of a wound to the sacrum prior to 8/26/24 when the following was documented, Resident seen by wound care r/t .unstageable pressure injury to the sacrum . Medihoney and calcium alginate with bordered foam dressing ordered to sacrum . A review of R22's Physician's Orders and August 2024 TAR revealed an order with a start date of 8/20/24 (It should be noted that the assessment done on 8/20/24 noted the pressure ulcer had been present for 14 days) for Honey gel to wound bed followed by calcium alginate and cover with bordered foam dressing every night shift and PRN (as needed) . A review of the August 2024 TAR revealed the treatment was not administered on 8/20/24, 8/21/24, and 8/23/24. Prior to 8/20/24, there was an order to apply zinc barrier cream every shift to the coccyx and sacrum that was started on 6/13/24 after R22 had a stage 2 pressure ulcer to the same area that was resolved. This order was discontinued on 8/27/24 but remained in place in addition to the treatment implemented on 8/20/24 through 8/27/24, which would have instructed nurses to administer two separate treatments to the area. On 8/28/24 at 9:59 AM, an observation of R22's pressure ulcer to the coccyx was conducted with LPN 'L'. Upon observation, there was no dressing on R22's coccyx wound. A half dollar sized unstageable pressure ulcer covered with yellow slough was observed. LPN 'L' reported the wound should have had a dressing applied. There were no loose dressings observed in R22's chair or bed. On 8/28/24 at 11:20 AM, an interview was conducted with the DON and LPN 'L'. When queried about when R22's sacral pressure ulcer was first identified, LPN 'L' reported she first assessed it on 8/20/24. LPN 'L' did not have an explanation as to why it was documented the wound was present for 14 days. When queried about the skin assessment dated [DATE] that did not identify any skin alterations to R22's coccyx/sacrum and whether LPN 'L' assessed it prior to becoming an unstageable pressure ulcer, LPN 'L' reported when she assessed the wound, it was already an unstageable pressure ulcer. Both the DON and LPN 'L' reported any changes in residents' skin should be immediately identified and reported to the DON and LPN 'L'. LPN 'L' reported on 8/20/24 she put an order in place for R22 to be laid down in between meals and the expectation was that the order was followed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of a facility policy titled, Skin Monitoring and Management - Pressure Ulcer, adopted 7/11/18, revealed, in part, the following, . A licensed nurse (which may be the facility Wound Nurse) must assess/evaluate a resident's skin at least weekly. All areas of breakdown, excoriation, or discoloration or other unusual findings must be documented in the resident's clinical record .A licensed nurse (which can be the facility Wound Nurse) must assess/evaluate at least weekly each wound, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to .describing the location of the wound .describing the progress with healing, and any barriers to healing which may exist .Once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order .All wound or skin treatments should be documented in the resident's clinical record at the time they are administered .In order to prevent the development of skin breakdown or prevent existing pressure ulcers from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: .Monitor impact of interventions and modify interventions as appropriate based on any identified changes in condition . Reposition the resident .Use pressure relieving/reducing and redistributing devices .If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative nurse's note documenting the notification .Re-evaluate existing treatment regimen in connection with the resident's clinical presentation .if any wound .is worsening .

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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** 32568 This citation has three deficient practice statements (DPS). DPS #1 Based on observation, interview, and record review, the facility failed to identify the root cause of multiple falls and implement effective interventions to prevent falls for one (R22) of two residents reviewed for falls, resulting in multiple falls with injuries including a bruise to the shoulder, a skin tear, and a bump to the head. Findings include: On 8/26/24 at 10:28 AM, R22 was observed lying in bed, chewing on her fingers, and moving around in the bed. R22 did not verbally respond when spoken to. A fall mat was observed on the floor beside the bed. On 8/26/24 at 1:18 PM, R22 was observed seated in a regular wheelchair in the dining room during lunch. R22 was hunched over and sleeping with a plate of food on the table. No staff members were observed seated with the resident at that time. On 8/26/24 at 3:58 PM, R22 was observed lying in bed. A foam wedge was observed next to the resident, which was not present during the earlier observation. R22's head was pressed against the wall and she was chewing on a blanket. On 8/27/24 at 8:01 AM, R22 was observed sleeping in a geriatric recliner chair (geri-chair) in her room. R22 was not in a geri-chair, the previous day on 8/26/24. R22 remained in the geri-chair during subsequent observations at 9:39 AM, 10:24 AM (in the dining room), 12:57 PM, and 1:30 PM. On 8/26/24 at 12:03 PM, a phone interview was conducted with R22's responsible party (RP). R22's RP reported R22 was a fall risk due to not having a lot of core strength and having poor insight into her ability to stand. R22's RP reported R22 would sometimes scoot to the edge of the wheelchair and fall. R22's RP reported she is concerned that the staff are not keeping an eye on R22 and she has fallen three times in the past one to two months. R22's RP reported the facility used to use a seat belt in R22's wheelchair to prevent her from falling but they took it away because they considered it a restraint. R22's RP reported she felt that if a seat belt was not able to be used, then other interventions should be implemented. A review of R22's clinical record revealed R22 was admitted into the facility on [DATE] with diagnoses that included: dementia. A review of R22's Minimum Data Set (MDS) assessment dated [DATE] revealed R22 did not speak, had severely impaired cognition, was dependent on staff for transfers, required substantial/maximum assistance for bed mobility, and had one fall with injury since the previous assessment which was on 5/3/24. On 8/27/24 at 9:06 AM, the Administrator and Director of Nursing (DON) was asked to provide all incident reports and associated investigations for R22 for the past six months. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following incident reports were provided and reviewed for R22, in addition to Fall assessments and Fall - Follow Up assessments : An incident report dated 6/22/24 at 10:30 PM for an Un-witnessed Fall documented, Observed resident on floor next to bed laying on right side. It was documented R22 sustained a bruise to the upper right back and the bed was placed in the lowest position and R22 was turned on her left side with a wedge in place. A review of a Fall assessment dated [DATE] revealed R22 was incontinent at the time of the fall, was lying in bed prior to the fall, and had a bruise to the right upper back. It was documented that the new interventions implemented post-fall were Bed height adjustment and items within reach. It was unknown if the bed was at the appropriate height at the time of the fall or if R22 was reaching for something and that caused the fall. A second incident report dated 7/1/24 at 8:00 PM for an Un-witnessed Fall documented, Resident was observed on the floor on left side in dinning <sic> room next to dinning <sic> table and her wheelchair . Patient unable to give description . It was documented the fall was not witnessed and R22 sustained a bump on her head on left side and a small skin tear on left shoulder. There were no documented statements on the incident report and no documented predisposing factors that may have contributed to the fall. There were no Fall assessments or Fall-Follow Up assessments in the clinical record and no investigation provided by the facility. There were no associated progress notes regarding that fall and no additional care planned interventions implemented afterward. No additional incident reports were provided by the facility. A review of R22's progress notes revealed documentation that indicated R22 had a fall on 7/29/24 when R22 was noted laying on the floor mat with her right side of face leaning on the foot of the bedside table. It was documented R22's bed was in the lowest position and wedges were placed on her side. Documentation in the progress notes indicated R22 fell again on 8/5/24 when she was noted to be laying down on the floor mat. Another fall as documented on 8/23/24 when R22 was observed on the top of the floor mat after R22's daughter requested staff to put R22 in bed. There was no documentation of what interventions were used to prevent R22 from falling out of bed. There were no associated incident reports for those falls. A review of a Fall-Follow Up assessment dated [DATE] did not indicate the root cause of the fall on that date. It was documented that staff was to check resident, anticipate her needs, and turn and reposition the resident. A day two Fall-Follow Up assessment dated [DATE] indicated R22 was to be repositioned every 2 hours, a floor mat was to be in place, kept clean and dry, and the call light within reach. All interventions that were already supposed to be in place at the time of the fall. There was no Fall-Follow Up assessment for the falls documented in the progress note on 8/5/24 and 8/23/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of R22's progress notes revealed a Care Plan Progress Note written by the DON on 8/12/24 that read, Writer spoke with (R22's RP) regarding her concerns about her mother's safety while sitting in a wheelchair. (R22's RP) feels that the current w/c (wheelchair) is not suitable and suggested a seatbelt, writer explained the primary cause of the falls are related to the residents positioning in the chair (it should be noted that there was no evaluation or investigation into the root cause provided during the survey). Writer recommended a Geri Chair instead. Writer contacted (Hospice agency) to discuss the ongoing issues with the residents falls. Writer requested an evaluation for Geri Chair . (It should be noted that on 8/26/24 R22 was observed in a regular wheelchair and on 8/27/24 R22 was in a Geri-Chair). Further review of R22's care plans revealed a fall care plan initiated on 9/4/24 that was revised on 8/23/24. An intervention initiated on 9/4/23 noted, If resident is restless assist up in gerichair in common area. All other interventions were initiated on 9/4/23 (and revised on 8/1/24 when the facility changed ownership, but the interventions remained the same). There were no interventions that included bed height or use of wedges. On 8/27/24 at 2:01 PM, an interview was conducted with the DON who had been in that position since 3/2024. When queried about how falls were reviewed in order to develop effective interventions to prevent future falls, the DON reported a risk management assessment was done (explained to be the incident report) which would trigger a fall evaluation that would be done for the next 72 hours. The DON explained that when the facility ownership changed on 8/1/24, the new process was that all falls went through the interdisciplinary team and therapy would provide recommendations. In addition, statements would be taken whether the fall was witnessed or not, and the resident's history and medications would be reviewed to determine what the root cause of the fall was and what interventions needed to be put into place. When queried about R22's falls and what was done to determine the root causes and who was responsible to implement new interventions, the DON reported prior to 8/1/24 she did not have any support and therefore things did not get done. The DON reported R22 recently got a Geri-Chair from hospice, but did not have an explanation as to why R22 was not seated in it on 8/26/24. At that time, the DON was given an opportunity to provide any additional information into R22's falls since 6/22/24. No additional information was provided prior to the end of the survey. A review of a facility policy titled, Fall Prevention, last reviewed 8/1/24, revealed, in part, the following, .The Director of Nursing/designee will be responsible for tracking resident falls .The Director of Nursing/designee will be responsible for ensuring that all residents who have been identified at risk or who have experienced a recent fall have all recommended interventions in place as well as current assessments . DPS #2 Based on observation, interview, and record review, the facility failed to provide care in a safe manner according to the resident's assessed level of assistance for one (R58) resident reviewed. Findings include: On 8/26/24 at 10:34 AM, R58 was observed positioned on his back in bed with a tracheostomy tube (a tube inserted into the windpipe to provide breathing assistance) and a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to directly provide nutrition). When spoken to, R58 did not make eye contact and did not verbally respond to questions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R58's clinical record revealed R58 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: diffuse traumatic brain injury with loss of consciousness, acute respiratory failure with hypoxia, type 2 diabetes, and seizures. A review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed R58 had severely impaired cognition, was dependent on staff all activities of daily living, transfers, and bed mobility (all assistance provided by staff), received all nutrition via a PEG tube, and had a tracheostomy tube to assist with breathing. On 8/27/24 at 10:32 AM, Certified Nursing Assistant (CNA) 'H' was observed entering R58's room with supplies, including linens, a gown, and a brief. An observation was made of CNA 'H' alone in R58's room preparing R58 for a brief change. No other staff members entered R58's room. When CNA 'H' exited R58's room with a bag of dirty linens and a brief, an interview was conducted. CNA 'H' was asked what tasks he performed while in R58's room. CNA 'H' reported he changed R58's brief, cleaned him up, and repositioned him. When queried about what level of assistance R58 needed and if a second staff member was required, CNA 'H' stated, I did it alone because I can. That's what I always do. When queried about how the CNAs know what level of assistance a resident needed for care, CNA 'H' reported he did not have access to the care plans or any instructions so he decides what to do. CNA 'H' reported they could also ask the nurse, but he did not ask the nurse regarding R58 because he had been taking care of that resident forever. On 8/27/24 at approximately 2:55 PM, an interview was conducted with the Director of Nursing (DON). The DON explained CNAs should refer to the Kardex (which is developed based on the residents' care plans) to determine the level of assistance a resident needed. The DON reported all CNAs have access. A review of R58's care plans revealed R58 required assistance of two staff members for bed mobility, which would have been required for changing a brief and repositioning R58 in bed. 38271 Deficient Practice #3 Based on interview and record review the facility failed to ensure appropriate resident supervision was provided to prevent multiple resident to resident altercations for one resident (R11) of one residents reviewed for accidents/supervision. Findings include: On 8/26/24 the medical record for R11 was reviewed and revealed the following: R11 was initially admitted on [DATE] and had diagnoses including Psychotic disorder with delusions, Anxiety and Dementia. A review of R11's comprehensive careplan revealed the following: Focus-I have behavior(s) related to (vascular dementia\delirium) as evidenced by: physically aggressive toward other residents, physically aggressive toward staff, refuses medications, resistant to care, wandering into other resident's rooms Date Initiated: 09/09/2023 . A review of R11's progress notes revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/9/2024 .Nurses' Notes: Heard loud commotion from the dining room. Entered dining room to see [R11] standing over another resident (R37) pouring coffee and grabbing at her. Residents were separated. Assessed resident that the coffee was poured onto for any injuries. Abrasion to right side cheek. and discoloration to lower right arm. Notified both family party. Notified unit nurse. Notified administrator. Notified MD (Medical Doctor). 5/15/2024 .Nurses' Notes: when this resident try to enter other resident room other resident stopped this resident with her arm. When stop this resident grabbed other resident face and scratched it . Administrator aware. Son aware. 3/24/2024 .Nurses' Notes: Staff observed the resident scratching another resident's face with her fingernails. The resident was standing over the other resident who was sitting in her wheelchair when she was observed by the aide scratching the resident's face while the other resident kicked at her legs. Resident was taken to another area of the hall and given dinner. Resident was calm with no behaviors after separated from the other resident On 8/28/24 at approximately 1:55 p.m., Nurse E was queried regarding their progress note and the incident with R11 pouring coffee on R37 and grabbing her. Nurse E indicated they walked into the dining room and R11 was standing over R37 and grabbing them. Nurse E indicated that R37 had coffee poured all down the side of them and that another resident had observed the whole incident and had informed them of what had happened. Nurse E was queried if any staff had been in the dining room to provide supervision since R11 already been identified as having physically aggressive behaviors and they indicated that no staff was in the dining room at that time. Nurse E indicated that R11 needed staff supervision.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41415 Based on observation, interview and record review the facility failed to timely identify and address the weight loss for one R25 of five residents reviewed for nutrition, resulting in the delay of an identified significant weight loss of -11.67% within six months and the delay of nutritional interventions implemented. Findings include: On 8/26/27 at 9:48 AM, R25 was observed laying down in their bed with their head slightly elevated sleeping with milk in their hand. R25's breakfast tray was observed uneaten in front of them. R25 was easily awaken with verbal stimuli. Once awake R25 did not respond to any questions, however continued to sip their milk. There was no staff observed in the room. On 8/26/27 at 9:48 AM, R25 was observed laying down in their bed with their head slightly elevated sleeping with milk in their hand. R25's breakfast tray was observed uneaten in front of them. R25 was easily awaken with verbal stimuli. Once awake R25 did not respond to any questions, however continued to sip their milk. A record review revealed R25 weighed 132 lbs (pounds) on 2/1/24, which was compared to the 8/4/24 weight of 116.6 lbs. This indicated a severe weight loss of -11.67% within 6 months. On 7/13/24 R25 weighed 122 lbs, compared to the 2/1/24 weight of 132 lbs, this indicated a -11.08 weight loss within five months. Further review of R25's weights revealed a gradual weight loss from April to August 2024, that was not timely identified. The facility staff failed to implement interventions to prevent further weight loss until 8/22/24. Review of the care plans revealed no additional nutritional interventions implemented and documented since 2023, prior to August 2024. Further review of the nutrition care plan documented an intervention to Provide assistance with meals as needed. Review of the facility policy titled Nutrition Monitoring & Management Program dated 8/1/24, documented in part . It is the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight . unless the resident's clinical condition demonstrates that this is not possible . Assessing the resident's nutritional status and the factors that put the resident at risk . Analyzing the assessment information to identify medical conditions . Monitoring and evaluating the resident's response or lack of response to the interventions . Revising or discontinuing the approaches as appropriate, or justifying the continuation of current approaches . Weight Loss . 10% in six (6) months, as well as unplanned weight loss that occurs over time that does not meet the guidelines for significant weight loss, should be addressed in the care plan . Ongoing interventions are evaluated and modified as needed . Any resident that various from the previous reporting period . Will be evaluated by the Interdisciplinary Team . Once weight . loss is identified . Any resident meeting the criteria for weight loss and any at risk will be weighed weekly . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R25 had not been weighed weekly and did not have orders to be weighed weekly at the time of the survey. On 8/27/24 at 1:02 PM, Registered Dietician (RD) C who was identified as the corporate dietician was interviewed and asked about the delayed identification of R25's weight loss and the delayed interventions implemented to prevent further weight loss. RD C stated they had started coming to the facility at the beginning of the month when the corporation they worked for took over the facility. RD C stated they could not answer for the previous Dietician, however implemented interventions once they identified the weight loss in August 2024. No further explanation or documentation was provided by the end of the survey.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Rochester Hills Rehab & Nursing Ctr	1480 Walton Blvd Rochester Hills, MI 48309

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41415 Based on observation, interview and record review the facility failed to ensure oxygen was administered as ordered by the physician for one R315 of three residents reviewed for respiratory care. Findings include: On 8/27/24 at 8:15 AM, Licensed Practical Nurse (LPN) A was observed administering R315's morning medications. LPN A was observed to have administered R315's medications and signed them as completed in the electronic record. LPN A was observed to document R315's 02 Sat (oxygen saturation) level as 97% on 4L (liters) of oxygen. An observation was conducted of R315's oxygen concentrator and was observed at 5L of oxygen being administered. At 8:53 AM, LPN A was asked to accompany the surveyor into the room of R315 and an observation was made of the residents oxygen concentrator. LPN A was asked to report the level of oxygen being administered. LPN A then stated it was 5L but it's 4L now, while being observed decreasing the oxygen to 4L. LPN A was then asked why they had signed off that R315 was receiving oxygen at 4L without checking and verifying the administration level of the oxygen being administered and LPN A acknowledged their error. Review of R315's physician order documented in part . 02 (oxygen) @ (at) 4 liters per minute via nasal canula . every shift for shortness of breath . The medical record revealed R315 was admitted with the diagnosis of shortness of breath. Further review of the medical record revealed no documentation on why R315's oxygen administration was increased to 5L. On 8/27/24 at 2:49 PM, the Director of Nursing (DON) was interviewed and informed of the observation with LPN A and R315. The DON stated the nurses should verify the oxygen levels ordered by the physician and verify the levels being administered before signing it off in the electronic record. Review of a facility policy titled Oxygen Administration dated 8/1/24, documented in part . It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained .

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure there was physician oversight for one (R58) of two residents reviewed for pressure ulcers, resulting in the lack of medical evaluation for a stage 2 (partial-thickness skin loss with exposed dermis) facility acquired pressure ulcer that worsened to a Stage IV pressure ulcer (Full-thickness skin and tissue loss) with acute osteomyelitis (bone infection). Findings include: On 8/26/24 at 10:34 AM, R58 was observed positioned on his back in bed with his neck tilted to the right side with a tracheostomy tube (a tube inserted into the windpipe to provide breathing assistance) and a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to directly provide nutrition). When spoken to, R58 did not make eye contact and did not verbally respond to questions. A review of R58's clinical record revealed R58 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: diffuse traumatic brain injury with loss of consciousness, acute respiratory failure with hypoxia, type 2 diabetes, and seizures. A review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed R58 had severely impaired cognition, was dependent on staff for transfers, toileting hygiene, bed mobility, and did not walk. The MDS assessment indicated R58 did not have any pressure ulcers at the time of the assessment. A review of a History and Physical from a hospital admitted d 7/20/24 (the day R58 was transferred to the hospital from the facility) revealed, .CT (Computed Tomography) abdomen pelvis showed gluteal region decubitis ulcers to the left of the midline with an open wound and multiple gas locules extending deep to the coccyx (tailbone) with concern for osteomyelitis . Further review of R58's clinical record revealed the following: A review of a Nursing Admission Evaluation dated 6/11/24 revealed no documentation of any skin impairments to R58's sacrum or buttocks. A review of a Skin & Wound Evaluation dated 7/4/24 revealed R58 had a Stage 2 pressure ulcer to the right ischial tuberosity that was in-house acquired as of 7/3/24. (It should be noted that upon interview with the Wound Care Coordinator, Licensed Practical Nurse (LPN) 'L' it was determined the pressure ulcer was located on R58's left side, not the right. It was documented the medical practitioner (Physician 'K') was notified. A review of a Skin & Wound assessment dated [DATE] revealed R58 had a Stage 3 pressure ulcer (Full-thickeness skin loss) to the right (left) ischial tuberosity that was identified on 7/3/24. It was documented the treatment was changed to medihoney and calcium alginate with bordered foam dressing. The assessment noted the practitioner was notified, but did not document the name of the provider. A review of a Skin & Wound Evaluation dated 7/18/24 revealed R58 had an unstageable pressure ulcer (obscured full-thickness skin and tissue loss) to the left ischial tuberosity that was in-house acquired since 7/3/24. It was documented Physician 'K' was notified. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R58's progress notes revealed R58 was transferred to the hospital on 7/20/24. A review of a Skin & Wound Evaluation dated 7/25/24 (after R58 was readmitted into the facility) revealed R58 had a Stage 4 pressure ulcer to the left ischial tuberosity, present since 7/3/24. There was no documentation of treatment and it was noted that the practitioner was notified. A review of all progress notes for R58 revealed R58 was seen by a physician on 6/20/24 for a competency evaluation and on 6/26/24 for a History and Physical by Physician 'I'. There was no documentation in the electronic medical record that indicated R58 was evaluated by a medical practitioner after 6/26/24, including after the development of a pressure ulcer that continued to worsen from a Stage 2 to a Stage 3/Unstageable and then a Stage 4 with acute osteomyelitis on the day R58 arrived at the hospital. The next time R58 was evaluated by a medical provider was on 8/13/24 when he was seen by the facility's newly contracted wound physician. On 8/28/24 at 8:54 AM, an interview was conducted with the Director of Nursing (DON). When queried about whether residents with pressure ulcers received evaluations by a medical provider, the DON reported the facility had an issue with some of the physicians seeing residents in a timely manner. When queried about whether the facility contracted with a wound provider, the DON reported the facility hired a wound physician on 8/1/24 and he started seeing residents on 8/13/24. On 8/28/24 at 9:20 AM, an interview was conducted with LPN 'L'. When queried about how it was ensured that residents with pressure ulcers were overseen by a medical provider, LPN 'L' reported she added residents to physician's logs when they developed pressure ulcers, but was not sure if they evaluated residents' wounds in the absence of a wound provider. LPN 'L' reported prior to 8/13/24, there was not a wound provider who came to the facility for some time. LPN 'L' reported all wounds were discussed during interdisciplinary team (IDT) meetings. On 8/28/24 at 11:25 AM, an interview was conducted with the DON. The DON confirmed there were no documented evaluations by a medical provider to address R58's pressure ulcer from the time it developed on 7/4/24 until 8/13/24 when the new contracted wound physician started seeing residents in the facility.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure one (R58) of 16 residents reviewed for physician visits was seen at least once every 30 days for the first 90 days after admission by a physician or physician extender. Findings include: A review of R58's progress notes since his admission into the facility on [DATE] revealed R58 was seen by a physician covering for Physician 'K' on 6/20/24 for a competency evaluation and by Physician 'I' on 6/26/24 for a History and Physical (H&P). On 6/26/24, a Medical Practitioner H&P progress note, written by Physician 'I' documented, I was asked to evaluate patient secondary to copious secretion, patient is unresponsive . positive for left-sided skull deformity .trachestomy with trach mask .PEG tube in place .Copious secretion . likely tracheitis (infection in trachea) .Start Levaquin (an antibiotic) .monitor clinically .seizure .continue Keppra (an anticonvulsant medication) .Diabetes .Continue insulin sliding scale . Further review of R58's clinical record revealed no evaluation by a medical provider after 6/26/24. Further review of R58's progress notes revealed the following documented events: On 7/1/24, it was documented in a Nurse's Note that R58 was staring blankly for a few seconds. Left note to MD (physician) . On 7/7/24, it was documented in a Nurse's Note that R58 was noted with yellowish sputum from trach site and had a temperature of 100.9 degrees Fahrenheit .In MD's log for tomorrow. On 7/20/24, it was documented R58 was transferred to the hospital after vomiting a large amount of [NAME] <sic>-brown emesis, loose stools, elevated respirations, and a fever of 103.3 degrees F. On 7/23/24, R58 was readmitted into the facility from the hospital. According to the hospital discharge instructions, R58 was diagnosed with acute osteomyelitis, aspiration of vomit, aspiration pneumonia, and sepsis. A review of R58's Skin & Wound Evaluations revealed R58 developed a stage 2 (partial-thickness skin loss) pressure ulcer on 7/4/24 that worsened to a stage 3 (full-thickness skin loss) on 7/11/24, and to an unstageable pressure ulcer (obscured full-thickness skin and tissue loss) on 7//18/24, and a stage 4 (full-thickness skin and tissue loss) on 7/20/24 with osteomyelitis as diagnosed in the hospital on the day of admission (7/20/24). There was no indication that a physician or physician extender saw R58 anytime between 6/26/24 and 8/27/24 despite a change in condition, emergency hospital admission, and development of a pressure ulcer. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 8:54 AM, an interview was conducted with the Director of Nursing (DON). When queried about how often residents were evaluated by a physician or physician extender, the DON did not offer a response regarding a time frame, but reported the facility had an issue with some of the physicians seeing residents in a timely manner. When queried about R58 and whether he should have been seen by a physician since 6/26/24 since he was admitted on [DATE], the DON reported he should have. On 8/28/24 at 11:25 AM, an interview was conducted with the DON. The DON confirmed there were no documented evaluations by a medical provider for R58 after 6/26/24.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure one (Certified Nursing Assistant - CNA 'H') of five CNAs reviewed for competency was evaluated for skills and techniques to care for residents' appropriately, resulting in CNA 'H' providing care to R58 in an unsafe manner and not according to assessed needs. Findings include: On 8/26/24 at 10:34 AM, R58 was observed positioned on his back in bed with a tracheostomy tube (a tube inserted into the windpipe to provide breathing assistance) and a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to directly provide nutrition). When spoken to, R58 did not make eye contact and did not verbally respond to questions. A review of R58's clinical record revealed R58 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: diffuse traumatic brain injury with loss of consciousness, acute respiratory failure with hypoxia, type 2 diabetes, and seizures. A review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed R58 had severely impaired cognition, was dependent on staff for all activities of daily living, transfers, and bed mobility (all assistance provided by staff). On 8/27/24 at 10:32 AM, Certified Nursing Assistant (CNA) 'H' was observed entering R58's room with supplies, including linens, a gown, and a brief. An observation was made of CNA 'H' alone in R58's room preparing R58 for a brief change. No other staff members entered R58's room. When CNA 'H' exited R58's room with a bag of dirty linens and brief, an interview was conducted. CNA 'H' was asked what tasks he performed while in R58's room. CNA 'H' reported he changed R58's brief, cleaned him up, and repositioned him. When queried about what level of assistance R58 needed and if a second staff member was required, CNA 'H' stated, I did it alone because I can. That's what I always do. When queried about how the CNAs know what level of assistance a resident needed for care, CNA 'H' reported he did not have access to the care plans or any instructions so he decides what to do. CNA 'H' reported they could also ask the nurse, but he did not ask the nurse regarding R58 because he had been taking care of that resident forever. A review of R58's care plans revealed R58 required two person assistance for bed mobility. On 8/28/24 at 2:21 PM, CNA 'H's personnel file was requested along with any competency evaluations and/or performance evaluations. A review of CNA 'H's personnel file revealed a date of hire of 9/7/23. There was no competency evaluation and/or skills checklist to verify CNA 'H' was evaluated prior to working with residents. On 8/28/24 at approximately 3:30 PM, an interview was conducted with the Administrator, who began working in the facility reported the facility identified a concern with competency evaluations and performance reviews and that they were not completed. The Administrator reported they were still working on it and have provided some education for nursing staff. Education sign in sheets were provided, but did not include following the care plan/Kardex or CNA 'H'. The Administrator reported moving forward all CNAs would have to demonstrate appropriate skills before being assigned to the floor.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure medically related social services were provided for eight residents (R7, R20, R48, R54, R59, R60, R312 and R315) of nine residents reviewed for social services. Findings include: During an onsite annual recertification survey conducted from 8/26/24 through 8/28/24 deficient practices were identified in multiple areas of social services, including the failure to provide the following: effective coordination of advance directives to ensure the residents' desired code status was properly documented in the clinical record, discharge planning resulting in an unsafe discharge without home health care services, completion of PASARR (Preadmission screening and resident review), and facilitation of ancillary services including dental and audiology, and assessment of residents for their social service needs. Resident #59 On 8/28/24 the medical record for R59 was reviewed and revealed the following: R59 was initially admitted on [DATE] and had diagnoses including Bipolar disorder and Dementia. Further review of R59's assessments and progress notes did not reveal any completed Social Service assessments to identify any medical/psychosocial needs. On 8/28/24 at approximately 3:07 p.m., a request to review R59's Social Service assessment was requested from the Administrator and Director of Nursing (DON). On 8/28/24 at approximately 3:20 p.m., the DON reported R59 did not have a Social Service assessment completed identifying any needs from the Social Service department. Resident #60 On 8/27/24 at approximately 10:51 a.m., R60 was observed in their wheelchair participating in the group meeting and indicated they wanted to speak to a Social Worker but has not been able to find one. R60 indicated they wanted to meet with one a few times a month while at the facility to get some help with discharge planning and applying for Social Security. On 8/27/24 the medical record was reviewed and revealed the following: R60 was initially admitted to the facility on [DATE] and had diagnoses including Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side. A review of R60's MDS (minimum data set) with an ARD (assessment reference date) of 6/20/24 revealed R60 needed assistance from facility staff with most of their activities of daily living. R60's BIMS score (brief interview for mental status) was 15 indicating intact cognition. Further review of R60's assessments and progress notes did not reveal any completed Social Service assessments to identify any medical/psychosocial needs. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at approximately 11:34 a.m., A request to review R60's initial Social Service assessment was requested from the Administrator and DON. On 8/28/24 at approximately 12:22 p.m., the Administrator followed up and indicated R60 did not have an initial Social Service assessment completed. On 8/27/24 at 9:44 AM, an interview was conducted with Human Resources Director (HR) 'E' and Corporate HR 'F'. According to HR 'F', the facility had a change in ownership on 8/1/24 and there was no qualified social worker employed at that time. HR 'F' reported the facility did hire a social worker who was starting on 9/4/24. At that time, documentation of the last day the previous social worker worked in the facility was requested. When queried about whether there are anyone providing full-time social services in the facility after the previous social worker resigned, HR 'F' reported various people were helping out since 8/1/24, but not onsite and not full time. Cross Reference: F578-(R48 and R315), F645-(R54), F660-(R312) , F685-(R7) , F791-(R20) and F850. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 a facility document titled Social Services-Director was reviewed and revealed the following: Position Summary: The Social Service Director is responsible to provide medically related social work services so that each Resident may attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. This position assesses and treats emotional and behavioral problems related to patient illness. Participates as a member of interdisciplinary team and may assist patients in treatment planning Principal Duties and Responsibilities: Responsible for operating the Social Services department within budgetary guidelines and limitations. Completes annual performance reviews of all subordinate staff; provides guidance and education to staff in relation to their performance. Provides counseling and disciplinary action to subordinate staff as needed. Responsible for training and educating staff in the Social Services department. Assesses and evaluates each Resident ' s psychosocial needs and develops goals for providing the necessary services and takes part in the admissions process as needed. Incorporates the Social Service goals in the Resident ' s Plan of Care and attends care planning conferences. Assists the Residents in adjusting to the facility and promotes a positive environment for the continuity of relationship with family and community. Assists Residents and families to utilize the community resources when not provided directly by the facility. Maintains confidential records and interviews with Residents and families as appropriate. Assists in the development, supervision, and education of staff. Serves as the team lead or assigns team lead to a staff in the department in discharge planning. Ensures completion of any required components of DPOA (durable power of attorney) or guardianship paperwork. Coordinates services with psychiatric providers. Coordinate services with OBRA (Omnibus Budget Reconciliation Act) including overseeing proper completion and management of the PASARR (Pre-admission screening annual resident review) program. Assists the Clinical IDT (interdisciplinary team) in resident room management. Assists Residents and families in resolving grievances as assigned. Attend Clinical IDT Meetings and serves as an advocate for Resident Rights. Reports all hazardous conditions, damaged equipment, and supply issues to appropriate persons. Assure that established infection control and standard precaution practices are maintained at all times. Follow established safety precautions when performing tasks and using equipment and supplies. Maintains the comfort, privacy and dignity of Residents and interacts with them in a manner that displays warmth, respect and promotes a caring environment. Communicates and interacts effectively and tactfully with Residents, visitors, families, peers, and supervisors. Answers and respond to call lights promptly and courteously when working in Resident care areas. Reports all Resident concerns to the appropriate department head. Attend and participate in departmental meetings and in-services as directed. Attends in-service and education programs and attends continuing education required for maintenance of professional certification or licensure. Understands Infection Control and follows the Company ' s Infection Control guidelines, such as hand washing principles. Maintains a high level of confidentiality in accordance with HIPAA (Health Insurance Portability and Accountability Act) guidelines at all times and protects confidential information by only providing information on a need-to-know basis. Promotes and Protects Resident Rights by assisting Residents to make informed decisions, treating Residents with dignity and respect, protecting Residents ' personal belongings, reporting suspected abuse or neglect, avoiding the need for physical restraints in accordance with current professional standards; and supporting independent expression, choice and decision-making consistent with applicable laws and regulations. Perform Related duties as assigned .Supervisory Responsibilities: Supervises employees in the department and others for whom they are administratively or professionally responsible (if applicable) by following policies and applicable laws. Uses independent judgment and discretion on behalf of the organization in the performance of these duties

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41415 Based on observation, interview and record review the facility failed to establish and implement an effective system to receive, dispense, administer and disposition of controlled medications account for two (R's 59 & 315) of five residents reviewed for medications, this deficient practice resulted in the inaccurate documentation of a controlled medication and had the ability to result in the diversion of medication not accounted for. Findings include: On 8/27/24 at 8:24 AM, Licensed Practical Nurse (LPN) A was observed preparing the morning medications for R315. LPN A was observed to obtain a morphine sulfate bottle, inside of a plastic bag with a folded controlled form for the morphine medication. The form was reviewed with LPN A and was observed to be blank. LPN A was asked how they were accounting for the unopened morphine medication if the document was blank. LPN A stated they don't account for the medication until they open the bottle. LPN A was asked to provide the current Morphine controlled form in use. Review of the Morphine controlled form that was in use revealed the facility staff was only counting the opened morphine bottle and not accounting for the unopened Morphine bottle, creating opportunity for diversion. LPN A was then asked to provide the opened Morphine bottle and when compared to the Morphine controlled form in use, confirmed the facility staff were failing to account for all of the Morphine medication on hand for R315. LPN A was asked how they count each controlled medication with the off going or incoming nurse and LPN A replied they don't account for each controlled pill or liquid, they only count full and half cards of medications and document it as such. LPN A stated this is how they were trained to do it at the facility. On 8/27/24 at 9:03 AM, the Administrator and Director of Nursing (DON) were asked to provide the facility's policy on the receipt, processing, count and maintenance of controlled medications. Review of the facility's policy provided revealed the following: Accepting Medication Delivery dated 8/1/24, was reviewed and contained no documentation for the receipt of controlled medications. Medication Access and Storage dated 8/1/24, was reviewed and documented in part . Schedule III and IV controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose . At 2:35 PM, the Administrator and DON were again asked to provide the policy for their protocol on receiving, disposition and reconciliation of the facility's-controlled medications in detail. Review of the policy provided titled Controlled Medication - Ordering & Receipt dated 2/2024 documented in part . A controlled medication accountability record is prepared when receiving or checking in a controlled substance medication for a resident. The following information is completed: Name of the resident, Prescription number, Drug name, strength . and dosage form of medication, Date received, Quantity received, Name of the person receiving the medication . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an additional policy provided titled Controlled Medication Storage dated 01/24 documented in part . At each shift change or when keys are surrendered, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses or approved individuals per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report . The facility failed to implement a system for their controlled medications. On 8/27/24 at 2:49 PM, the DON was interviewed, informed of the observation of LPN A and the incident with the Morphine medication and the DON replied they were trained under the previous corporation (the facility had recently been taken over by a new corporation) that they don't specific non controlled medications from controlled medications and count the cards as full or halves. The DON stated the new corporation had a better system in place which would be implemented. No further explanation or documentation was provided by the end of the survey. 32568 Resident #59 (R59) On 8/27/24 at 11:06 AM, LPN 'A' was observed at the medication cart located on the North East Unit. LPN 'A' was observed going through the double locked box that contained controlled substance medications and comparing the number of pills with what was written on the controlled substance count sheet. LPN 'A' was observed writing on the count sheet without removing a tablet from the supply. At that time, LPN 'A' was interviewed and the controlled substance count sheet was observed. It was for R59 (klonopin - an antianxiety medication). LPN 'A' dated the entry 8/27/24 at 9:00 AM (two hours earlier) and documented that he removed one pill from the supply with a total count of 13 pills. When queried about why he documented that a pill was removed when it was not, LPN 'A' reported he gave the medication earlier in the morning but did not document it on the count sheet. When queried about the appropriate process for accounting for controlled substances, LPN 'A' reported he should have documented the removal of the pill at the time it was removed and administered. On 8/27/24 at approximately 3:00 PM, the DON was interviewed. The DON reported that any controlled substance that was removed from the supply should be documented on the associated count sheet for that medication at the time it was removed.

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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. 41415 Based on observation, interview and record review the facility failed to follow the facility's policy on the maintenance and storage of medications and foods for one of one medication storage rooms observed. Findings include: On 8/27/24 at 8:20 AM, an observation of the medication back up storage room refrigerator was conducted. A refrigerator temperature check list was observed with the date of 8/20/24 to have been the last date staff had checked the temperature of the refrigerator. Two applesauce containers were found in the refrigerator next to medications and insulins that were also stored in the refrigerator. The Director of Nursing (DON) was asked to confirm the findings and stated the nightshift nurses are responsible for checking the refrigerator temperature. The DON stated they would start education with their staff. The DON also stated there should be no food stored in the refrigerator with the residents medications and if so, should be separated. Review of a facility policy titled Medication Access and Storage review date of 8/1/24, documented in part . It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls . Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated, and separate from fruit juices, applesauce, and other foods used in administering medications. Other foods (e.g., employee lunches, activity department refreshments) are not stored in this refrigerator .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure a dental oral surgery referral was made for one resident (R20) of one residents reviewed for dental services. Findings include: On 8/27/24 at approximately 11:03 a.m., R20 was observed in the group meeting and indicated that they were supposed to have their tooth taken out in January but had no assistance from the facility in getting the procedure completed. On 8/27/24 at approximately 3:04 p.m., R20 was observed in the hallway, up in their wheelchair and expressed concerns about their tooth hurting and needing to be pulled. R20 indicated again that nobody was going to do anything about it. On 8/27/24 the medical record for R20 was reviewed and revealed the following: R20 was initially admitted to the facility on [DATE] and had diagnoses including Pain and Dysphagia. A review of R20's MDS (minimum data set) with an ARD (assessment reference date) of 7/20/24 revealed R20 needed assistance from facility staff with most of their activities of daily living. R20's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A Dental evaluation dated 2/15/24 revealed the following: Confirmed with facility patient is Covid-19 negative and afebrile.; Reviewed Medical History; Patient has plaque and calculus build-up, recommend cleaning and exam every 6 months; Patient masticating well.; Stressed brushing twice per day to maintain health of teeth and tissues.; Patient has discomfort from fractured teeth #2, #19. Refer to oral surgeon for extractions due to need for surgical extractions and health issues. Tooth #8 DFL caries .Action required by Nursing home staff: Referral to oral surgeon for extraction of teeth #2, #19 surgical extractions . A second dental evaluation dated 4/26/24 revealed the following: Treatment notes: Patient complains of pain in lower left and upper right .#19 is non-restorable and causing the patient pain, irreversible pulpitis and/or symptomatic apical periodontitis. Both #2 and #3 have fractures with caries in them, and due to the communication issues with the patient, it is not possible at this moment to discern which tooth is bothering him. He gives no concrete answer to the presence of cold in his mouth on these teeth and percussion and palpation do not yield anything useful. Patient unable to effectively communicate. Note to hygiene: please take PA (posterior-anterior) of #2 and #3, so that it may be possible to find out which tooth is causing the patient discomfort .Action required by Nursing home staff: Refer to MD/OS (medical doctor/oral surgeon) for extraction of tooth; Please refer for extraction of #19 . A progress note dated 7/8/202410:00 Nurses' Notes: Resident LOA (leave of absence) to dentist appt (appointment) via harmony transportation accompanied by cena (certified educated nurse assistant). A second progress note dated 7/8/2024 revealed the following: Resident returned back to the facility. Unable to be seen without guardian present with him. Appointment needs to be rescheduled. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at approximately 3:25 p.m., during a conversation with the Administrator (providing social service oversight) the Administrator was queried regarding the lack of oral surgeon referral being made and they indicated that they have been without a social worker who would usually make those referrals and had recently hired a new one. The Administrator indicated that they would have to make R20 a dental appointment to get their tooth extracted.

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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. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 8/26/24 at 9:10 AM, there was raw chicken observed under running water directly inside the sink basin of the 2 compartment sink. The internal temperature of the chicken was measured to be 67 degrees Fahrenheit. When queried, Dietary Staff M stated the chicken was in the walk-in cooler, but was still frozen, so it was placed in the sink to thaw. No explanation was given as to why the chicken was still in the sink basin with an internal temperature of 67 degrees Fahrenheit. According to the 2017 FDA Food Code section 3-501.13 Thawing Except as specified in (D) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be thawed: 1. (A) Under refrigeration that maintains the FOOD temperature at 5 C (41 F) or less; or 2. (B) Completely submerged under running water: 1. (1) At a water temperature of 21 C (70 F) or below, 3. (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5 C (41 F). On 8/26/24 at 9:20 AM, in the walk-in cooler, there was an undated pan of leftover enchiladas, an undated pan of white sauce, an undated pan of gravy, an opened undated package of bologna, an opened undated 1 gallon container of Italian dressing and ranch dressing, and a 1 gallon container of creamy Caesar dressing dated 6/17-7/17. Dietary Staff M confirmed the items should have been dated when opened. According to the 2017 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 48680 Based on observation, interview and record review, the facility failed to ensure a plan of care for hospice services being provided was coordinated and documented in the resident's clinical record for one (R315) of one sampled resident reviewed for hospice services, resulting in a lack of coordination of comprehensive services and incorrect code status. Findings include: On 8/25/24 at 10:20 AM, R315 was observed lying in bed with a family member present. An interview was held with R315. R315 was then asked how the care was received at the facility and stated that they were only here for a short period of time because they were a hospice respite patient (at the facility for a short period of time). On 8/27/24 at 3:00 PM, the Director of Nursing (DON) was interviewed and asked how the facility communicated with the hospice company for R315. DON replied that we have been doing everything verbally, there is no actual book or log (to communicate with hospice) at this moment. The DON continued by stating , I have told the administrator (about the communication concern), and they will communicate to the hospice company about our requirements and expectations. There was no additional information provided by the exit of the survey.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 32568 Based on interview and record review, the facility licensed failed to employ a full-time qualified social worker when certified for 126 residents, resulting in multiple deficient practices including the following areas, advance directives, ancillary services, completing Social Service assessments, discharge planning, and Preadmission Screening and Resident Review (PASRR). This deficient practice had the potential to affect all 62 residents who resided in the facility. Findings include: During an onsite annual recertification survey conducted from 8/26/24 through 8/28/24 deficient practices were identified in multiple areas of social services, including the failure to provide the following: effective coordination of advance directives to ensure the residents' desired code status was properly documented in the clinical record, discharge planning resulting in an unsafe discharge without home health care services, completion of PASRR, and facilitation of ancillary services including dental and audiology, and assessment of residents for their social service needs. A review of a Facility Assessment Tool provided by the facility revealed the facility was licensed to provide care to 126 residents. On 8/27/24 at 9:44 AM, an interview was conducted with Human Resources Director (HR) 'E' and Corporate HR 'F'. According to HR 'F', the facility had a change in ownership on 8/1/24 and there was no qualified social worker employed at that time. HR 'F' reported the facility did hire a social worker who was starting on 9/4/24. At that time, documentation of the last day the previous social worker worked in the facility was requested. When queried about whether there are anyone providing full-time social services in the facility after the previous social worker resigned, HR 'F' reported various people were helping out since 8/1/24, but not onsite and not full time. A review of Termination Information for the former social worker, SW 'G', revealed SW 'G' last day worked in the facility was 3/28/24 with a termination date of 4/17/24. Cross-Reference F578, F645, F660, F685, F745, and F791

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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** 41415 Based on observation, interviews and record reviews the facility failed to ensure infection control standards and practices were consistently implemented (R58) and ensure an effective infection control prevention and control program was consistently implemented for 62 of 62 residents residing at the facility during the time of the survey. Findings include: A review of the facility's Infection Control Surveillance program provided by the Infection Control Nurse (ICN) J who also served as the facility's Infection Preventionist was conducted and revealed the following: - No monthly Infection Control Analysis report for May, June or July 2024 - No surveillance log for July 2024 Further review of the program revealed inaccurate mapping of infections. Review of the July 2024 antibiotic audit revealed three residents treated with antibiotics for a urinary tract infection and only one resident was identified on the facility's mapping. On 8/28/24 at 11:12 AM, a meeting to review the facility's infection control program was conducted with ICN J. ICN J explained how they were hired three months prior and took responsibility of the facility's infection control program at that time. When asked, ICN J stated they also had the responsibility of being the facility's staff development coordinator, unit manager and cart nurse when needed. When asked how many hours out of the week they devoted to the Infection Control Program, ICN J stated . four hours out of every eight hour shift . ICN J was asked about the missing monthly analysis reports that are generated to oversee the facility's infections and present to the facility's QAPI (Quality Assurance Performance Improvement) program. ICN J stated they were unaware of what the analysis report was. April 2024's analysis report was reviewed with ICN J and ICN J stated they had questions regarding the math and determining the infections for the report. ICN J stated they had not completed a report since resuming the role. ICN J stated the new corporation is implementing a new system for them to complete the infection surveillance and monthly analysis. ICN J was then asked how many QAPI meetings they attended since employment and ICN J replied they attended one meeting. ICN J stated the meetings are held monthly, however the facility had recently transitioned to a different corporation and had not been held monthly. ICN J was then asked about the inaccurate mapping of infections for July 2024. ICN J reviewed the program and stated they must have missed it. Review of the facility's policy titled Infection Prevention and Control Program Overview last dated 8/1/24, documented in part . The infection prevention and control program is comprehensive in that it addresses the prevention, identification, reporting, investigation and controlling of infections and communicable diseases among residents, employees, volunteers and visitors . There is on-going monitoring for infections among residents . Infection prevention and control is a component of the facility's quality assessment and assurance program and infection prevention and control reports are made to the QAA (quality assurance) committee . No further explanation or documentation was provided by the end of the survey. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	32568 Resident #58 (R58) On 8/26/24 at 10:34 AM, R58 was observed positioned on his back in bed with a tracheostomy tube (trach) (a tube inserted into the windpipe to provide breathing assistance) and a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to directly provide nutrition). When spoken to, R58 did not make eye contact and did not verbally respond to questions. A review of R58's clinical record revealed R58 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: diffuse traumatic brain injury with loss of consciousness, acute respiratory failure with hypoxia, type 2 diabetes, and seizures. A review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed R58 had severely impaired cognition, was dependent on staff all activities of daily living, received all nutrition via a PEG tube, and had a tracheostomy tube to assist with breathing. On 8/27/24 at 11:06 AM, the skin underneath R58's foam trach collar tie was observed with Licensed Practical Nurse (LPN) 'A'. Upon lifting up the trach tie, a large amount of secretions was observed on R58's neck. At that time, LPN 'A' reported he was going to clean the secretions from R58's neck. LPN 'A' donned gloves located outside of the room and a sterile trach kit was opened that contained supplies and sterile gloves. LPN 'A' removed the gloves he was wearing and donned the gloves in the sterile kit without performing hand hygiene in between the glove change. LPN 'A' then used the gauze in the kit to wipe the secretions from R58's neck and underneath the trach mask. After the secretions were cleaned, LPN 'A' proceeded to apply clean gauze under the trach mask without changing gloves and performing hand hygiene. On 8/27/24 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON). When queried about when hand hygiene and gloves changes should occur during trach care, the DON reported whenever you are going from dirty to clean. The above observation was shared with the DON. The DON reported LPN 'A' should have removed his gloves, performed hand hygiene, and donned clean gloves between cleaning the secretions and applying clean gauze.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 41415 Based on interview and record reviews the facility failed to maintain and implement an effective antibiotic stewardship program for five (R1, R11, R23, R58, R212) of five residents identified, however this deficient practice had the ability to affect multiple residents that were prescribed and administered antibiotics while residing in the facility. Findings include: A review of the April, May, and June 2024 Infection Surveillance logs revealed no documentation of any of the documented infections to have met or not met the criteria of an infection. Review of the Surveillance logs revealed the following: - April 2024- R23 was prescribed and administered Cephalexin 500 mg (milligram) three times a day for a right arm selling/pain from an IV (intravenous) site from the hospital. Review of the April 2024 infection log documented in part . Started on ATB (antibiotic) as prophy (prophylaxis). Sent to hospital and found to have a GI (gastroenterology) bleed and no infection so DCed (discontinued)). The antibiotic was signed off until completed, however the resident was sent and admitted to the hospital prior to its completion. Further review of April 2024 surveillance documented R212 was . Readmit from hospital with ATB (antibiotic) therapy for pneumonia . Doxycycline 100 mg every 12 hrs.(hours) for Pneumonia was started on 4/17/24. Review of the medical record revealed no documentation of the review of the antibiotic or appropriateness. - June 2024- R58 was documented as . Infection- Other . Levaquin 500 mg . there was no documentation of the type of infection identified or if the infection met criteria. Review of the physician orders and June 2024 Medication Administration Record (MAR) documented the antibiotic to have been administered once daily for Infection for seven days. Review of the program and R58's record revealed no documentation of the appropriateness of the antibiotic. Further review revealed R1 was prescribed Amoxicillin-Pot Clavulanate 875/125 mg for a urinary tract infection (uti). The surveillance log did not identify if the infection met criteria. Review of R1's June 2024 MAR documented the antibiotic was administered twice a day for . bacterial infection for 10 days . Review of R1's medical record revealed no documentation of signs/symptoms that met criteria for a uti and no documentation of the appropriateness of the antibiotic. - July 2024- R11 was identified on an antibiotic audit due to no surveillance log to have been completed for the month of July 2024. The audit document Macrobid 100 mg twice a day for a uti. Review of the program revealed no documentation of the infection to have met criteria or the appropriateness of the antibiotic. Review of the medical record revealed documentation of a urinalysis to have been completed, however R11's record did not contain results of a urinalysis or culture report. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at approximately 11:22 AM, the Infection Control Nurse (ICN) J who also served as the facility's Infection Preventionist was interviewed and asked the criteria the facility utilized and ICN J replied McGeers criteria. ICN J was then asked how they identified if the infection met criteria and what tool they utilized to determine if it met or not. ICN J stated there was a new program that the new corporation was implementing for their infection control program. Once transitioned, ICN J stated the software would inform them if it met criteria. ICN J was then asked how they confirm the appropriateness, length and time of an antibiotic and ICN J stated they would review the physician orders and notes. ICN J was asked where they or the physician document if an infection met criteria and the appropriateness of prescribed antibiotics and ICN J replied they had not document it in the past, however, will implement it moving forward. Additional documentation was provided by ICN J and reviewed, however the concerns of infections meeting criteria and concern of the appropriateness of antibiotics remained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235036	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs at Rochester Hills Rehab & Nursing Ctr	1480 Walton Blvd Rochester Hills, MI 48309

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on interview and record review the facility failed to provide education and offer the pneumococcal immunization for two R's 26 & 58 of five residents reviewed for the Pneumococcal immunization. Findings include: R26 Review of R26's medical record revealed no documentation of the resident and/or representative to have been educated and offered the pneumococcal immunization. Further review of the medical record revealed no documentation of the immunization to be medical contraindicated or noted the resident to already be immunized. R26 was admitted to the facility on [DATE]. R58 Review of 58's medical record revealed no documentation of the resident and/or representative to have been educated and offered the pneumococcal immunization. Further review of the medical record revealed no documentation of the immunization to be medical contraindicated or noted the resident to already be immunized. R58 was admitted to the facility on [DATE] and had a readmitted [DATE]. Review of the facility's policy titled Pneumococcal Vaccine dated 8/1/24, documented in part . It is the policy of this facility that all residents will be offered the pneumococcal vaccines to aid in preventing pneumonia . Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccines and when indicated, will be offered the vaccinations, unless medically contraindicated or the resident has already been vaccinated . Before receiving the pneumococcal vaccines, the resident or responsible party shall receive information and education regarding the benefits and potential side effects of pneumococcal vaccines . On 8/28/24 at 11:37 AM, the Infection Control Nurse (ICN) J who oversees the Pneumococcal vaccinations in the facility was interviewed and asked the facility's process on educating and the administration of the Pneumococcal vaccine. ICN J stated the vaccine is offered upon admission. ICN J stated they have a new process in place under the new ownership that will bundle the education and consents for all immunizations. ICN J was asked to provide the education and consents provided to the R's 26 & 58 and/or their representatives. ICN J stated they would look into it and follow up. A short time later ICN J returned and stated they were unable to find the requested documentation, however both residents/representatives will be educated and offered today 8/28/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on interview and record review the facility failed to provide education and offer the Covid-19 vaccine and/or booster for two R's 26 & 58 of five residents reviewed for the Covid-19 vaccine. Findings include: R26 Review of R26's medical record revealed no documentation of the resident and/or representative to have been educated and offered the Covid-19 Vaccine. Further review of the medical record revealed no documentation of the vaccine to be medical contraindicated or noted the resident to have already received the vaccine and/or booster. R26 was admitted to the facility on [DATE]. R58 Review of 58's medical record revealed no documentation of the resident and/or representative to have been educated and offered the Covid-19 Vaccine. Further review of the medical record revealed no documentation of the vaccine to be medical contraindicated or noted the resident to have already received the vaccine and/or booster. R58 was admitted to the facility on [DATE] and had a readmitted [DATE]. Review of a facility policy titled COVID-19 Vaccine dated 9/23/23, documented in part . It is the policy of this facility that all residents will be offered the COVID19 vaccines to aide in preventing COVID19 infections and outbreaks . Residents will be assessed for eligibility to receive COVID19 vaccines and when indicated, will be offered the vaccinations, unless medically contraindicated or the resident is up to date with vaccination, as recommended by CDC (Centers for Disease Control and Prevention) . Before receiving the COVID19 vaccines, residents or responsible parties shall receive information and education regarding the benefits and potential side effects . On 8/28/24 at 11:37 AM, the Infection Control Nurse (ICN) J who oversees the COVID-19 vaccinations in the facility was interviewed and asked the facility's process on educating and the administration of the COVID-19 vaccinations and/or boosters. ICN J stated the vaccine is offered upon admission. ICN J stated they have a new process in place under the new ownership that will bundle the education and consents for all immunizations. ICN J was asked to provide the education and consents provided to the R's 26 & 58 and/or their representatives. ICN J stated they would look into it and follow up. A short time later ICN J returned and stated they were unable to find the requested documentation, however both residents/representatives will be educated and offered today 8/28/24.