STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235044	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay County Medical Care Facility	564 W Hampton Road Essexville, MI 48732

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Number MI00143143. Based on interview and record review, the facility failed to prevent staff-to-resident verbal abuse for one resident (Resident #47) of three residents reviewed, resulting in a staff yelling at and calling Resident #47 derogatory names, Resident #47 expressing signs and symptoms of distress and fear, and the likelihood for ongoing psychosocial distress utilizing the reasonable person concept. Findings include: Resident #47: On 3/11/24 at 11:26 AM, Resident #47 was observed in their room in bed. A Hoyer lift was observed in the room. When asked questions, Resident #47 responded but did not provide meaningful responses. Record review revealed Resident #47 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral palsy, intellectual disabilities with cognition of a five- to seven-year-old, epilepsy, heart failure, depression, anxiety, weakness, and pain. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired, displayed physical and verbal behaviors towards others, and was dependent/required maximum assistance from staff for all Activities of Daily Living with the exception of eating. Review of Resident #47's Electronic Medical Record (EMR) revealed the following progress note documentation: - 2/2/24 at 6:35 PM: It was reported a staff member witnessed an inappropriate statement made by CNA (Certified Nursing Assistant) in front of resident. CNA in question removed from resident and situation. Resident interviewed and was visibly upset. Emotional support given . - 2/23/24 at 3:50 PM: SW (Social Worker) visited with (Resident), also asked nurse how (Resident) has been during care. Nurse replied that (Resident) scratched CNA during care yesterday and was very apologetic regarding such right after. (Resident #47) then asked SW if they were going to jail. SW asked if mom/parents told them that they would go to jail when they were young to which replied, 'Yes, when you're bad!' SW reassured (Resident #47) that they were not going to jail . (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/4/24: (Resident #47) asked to speak with social services today. (Resident #47) states . upset at self this morning with how behaved towards staff during med pass . asked if we were 'calling the cops and if he was going to jail' . reassured that cops were not called and was not going to jail. (Resident #47) stated 'I hope not, I'm afraid'. Offered reassurance . Review of Resident #47's care plans revealed a care plan entitled, Mood/Behavior: I have difficulty with my mood at times r/t (related to) my dx (diagnoses) of ID (Intellectual Disability), Delusional Disorders . Depression . I am usually pleasant and cooperative; I like to people watch, visit with staff or other residents . Due to my mental age of 5-7 years, I do not always understand information when it is told to me or when communicating with others. Sometimes I become agitated and upset if I do not understand. I express anxiousness and will ask staff if I'm going to jail or if staff are 'going to call the police' . I become agitated with excessive noise, and I startle easy at times. I can be resistive or combative with care. I have a history of verbal and occasional physical aggression toward prior housemates. I also have a history of biting myself when upset. I occasionally yell out at other residents if they are being loud or bothersome to me (Start: 11/27/18; Reviewed/Revised: 3/8/24) Review of facility provided incident investigation documentation for Resident #47 revealed an allegation of staff-to-resident verbal abuse occurred on 2/2/24. The provided documentation included: - A typed, undated and unsigned summary form which specified the facility Administrator was notified on Friday, 2/2/24 at approximately 7:10 PM by Registered Nurse (RN) S that Certified Nursing Assistant (CNA) T witnessed CNA U yelling at (Resident #47), repeatedly threatening (the Resident) that they were going to call the cops and well as saying (Resident #47) was being a jerk off and that they need to learn to act f***ing right when they went into the Resident's room to assist with care. The summary revealed CNA T told CNA U they would take over providing care to the Resident, but CNA T did not leave the room and CNA T stayed in the Resident's room to ensure they were safe. CNA T reported the incident to the unit nurse following the incident. - Updated Written Statement by CNA T which specified, Answered residents staff assist light. Aide (CNA) called Resident (#47) a 'jerk off.' While providing care, Aide aside that the Resident needs to 'learn how to act fu**ing right.' Aide continuously threatened to call cops on resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Emailed Statement from CNA U to the Administrator, dated 2/2/24 at 9:25 PM: I took (Resident #47) into their room to get ready for bed . asked me to put fights on the TV. I told (Resident #47) that I would get someone else to help them with it . I don't know how to work their DVR. This is something we talk about every time I get (Resident #47) into bed. I went to help (the Resident) get undressed and into night clothes. (Resident #47) would not cooperate with me. I told (Resident #47) I would have someone come in and help us. After the other aide came in, (Resident #47) was yelling at me. The other aide got (Resident #47) to cooperate with us so we could get them changed. During this time, (Resident #47) was yelling at me and telling me they hated me. I told (Resident #47) that I don't care that they hate me, that I still needed to help them get into bed and clean up. During this whole time, (Resident #47) kept hitting at me and telling me that they hated me. (Resident #47) did say at one point that they wanted the other aide to help them and not me. The other aide told me that if needed, they would help (Resident #47) by themselves. I did not want (Resident #47) to start yelling and hitting (CNA T), so I told (Resident #47) that I was there to help them, and I was not going to leave. At one point I do remember telling (Resident #47) that if they didn't stop hitting me, that I would call the police. I only said this because I have heard other aides say it, and it seemed to calm (Resident #47) down a lot. This time, it did not calm them down. (Resident #47) continued to be aggressive toward me while we were doing care. While (Resident #47) was still in their chair, they were mean to (CNA T) and I told them that they should talking to my aide like that . (Resident #47) calmed down after care was down and (CNA T) turned on TV for them . - Emailed Statement from the Director of Nursing (DON) to the Administrator, dated 2/4/24 at 6:19 PM: On [DATE]rd, 2024, I spoke with (CNA U) regarding the incident with (Resident #47). (CNA U) stated they went into (Resident #47's) room to get them into bed . (Resident #47) was not cooperating. (CNA U) asked (Resident #47) to lean forward so they could remove their shirt and they leaned back instead. (CNA U) pushed the call light for help at this time. (Resident #47) wanted to watch wrestling on their DVR and they stated they told (Resident #47) I do not know how to run the DVR and said (Resident #47) knew we cannot run the DVR. (CNA U) said they told (Resident #47) 'as soon as I get you into bed and get you dressed for the night, I will get someone to help us with it.' (CNA U) stated (CNA T) came in to help . (CNA U) said that (Resident #47) was yelling at them, hitting . and saying they hated them. (CNA U) stated that (CNA T) . asked if they wanted them to take over (Resident #47's) care but (CNA U) stated they did not want to leave (CNA T) in there by themselves in case (Resident #47) did that to them. (CNA U) stated that (CNA T) stated the whole-time during care. (CNA U) stated that at one point they said to (Resident #47), 'if you don't stop, I am going to call the cops. (CNA U) stated that they have never swore at a resident. I asked why they said that to Resident #47 and (CNA U stated, 'I was in a room with another aide before and they said that to (Resident #47) to calm them down' . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Typed Statement by RN S, dated 2/2/24: I was notified by LPN (Licensed Practical Nurse) that (CNA T) reported they answered a call light to a resident's room that was put on for assistance with a resident. (CNA T) reported as they were assisting (CNA U) wit care, (CNA U) was yelling at (Resident #47) and repeatedly threatening resident that they were going to call the cops on them if they didn't calm down, also that they needed to learn and grow up or they would tell their Mom and Dad. (CNA T) reported they told (CNA U) they would care of resident, and it would be best to leave the room and the resident clearly voiced they did not want (CNA U) taking care of them. (CNA T) reported they had asked (CNA U) at least 3 different times to please leave the resident's room. (CNA T) stated (CNA U) continued to threaten resident with calling the cops and (CNA U) would not leave room. After HS (before bed) care was completed, (CNA T) immediately reported (CNA U's) behavior to their LPN supervisor. As I entered (Resident #47's) room, resident was visibly upset . kept repeating, 'I sorry, I go jail. Don't like her. I go jail. I sorry. I sorry. Her say f**ckin bi**ch me.' Resident comforted and became calmer after being reassured the cops were not coming and they are absolutely safe . I spoke with (Administrator) and made aware. I let (CNA U) know they would have to leave for the rest of this shift and possible the weekend until further notice. (CNA U) shouted, 'So what am I fired? All I did was them (Resident #47) I was going to call the cops on them! I was told to do that because it calms them down.' . - Email documentation indicating CNA U's employment was terminated as of 2/5/24 - Eight typed resident interview questionnaires with the questions, Do you feel safe here? and Have you overheard staff saying anything inappropriate or negative? Note: The investigation documentation did not include an interview with Resident #47 and/or all other staff working. An interview was completed with the facility Administrator on 3/12/24 at 11:48 AM. When queried regarding the incident involving Resident #47 and CNA U, the Administrator verified the facility determined the allegation occurred and terminated the staff member's employment. No further explanation was provided. On 3/12/24 at 1:37 PM, an interview was conducted with the DON. When queried regarding the incident involving Resident #47 and CNA U, the DON stated, I was contacted and then I let (the Administrator) know. When queried regarding their role in the investigation, the DON replied they conducted interviews and revealed the facility concluded the allegation of verbal abuse had occurred and CNA U's employment was terminated. When queried regarding the staff written statements stating CNA U told the Resident they were going to call the police on them and the implication that other unidentified staff also told the Resident the same thing, the DON revealed they were able to identify the staff member CNA U was referring to through questioning as CNA V. The DON revealed the Resident has fear from childhood trauma and stated, I spoke to (CNA V) and they said that (Resident #47) was upset and (saying) 'call the cops' before and they were trying to figure out what was going on. When asked what staff were assigned to care for the Resident on 2/2/24 at the time of the incident, the DON revealed CNA U was assigned to Resident #47 and CNA T went into the room to assist them. When queried if CNA U provided care to the Resident and/or entered their room after the incident occurred, the DON indicated they were not aware of the staff member entering the Resident's room again but revealed they were not in the building. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with CNA T on 3/12/24 at 1:51 PM. When queried regarding the incident involving Resident #47 on 2/2/24, CNA T stated, I answered a staff assist light and (CNA U) said, '(Resident #47) is being a real jerk off.' I offered to take over (care) because (Resident #47) was clearly upset but (CNA U) refused to leave. When queried if they offered to take over care as soon as they entered the room, CNA T revealed they offered as soon as they got into the room and several other times. CNA T revealed the Resident said they did not want CNA U to take care of them and was upset. CNA T then stated, (CNA U) threatened to call the cops repeatedly. It made (Resident #47) upset. CNA T was asked how they knew Resident #47 was upset and stated, I work with (Resident #47) a lot and I could tell. (Resident #47) was distraught even after when I went to check on them. When queried what happened after care was completed, CNA T stated, We walked out together. CNA T was asked what they did after exiting Resident #47's room and stated, I went to the LPN, and they reported it to the RN. When queried if CNA U went back into Resident #47's room, CNA T stated, I am not 100% sure. CNA U was asked if they had worked with CNA T before 2/2/24 and indicated they had not. On 3/12/25 at 1:57 PM, an interview was attempted to be completed with CNA T. A voicemail message was left with return number. A return call was not received by the conclusion of the survey. On 3/12/24 at 3:31 PM, an interview was conducted with RN S. When queried regarding the incident on 2/2/24 involving Resident #47, RN S revealed they were the RN supervisor for the shift and were on a different floor of the facility when it occurred. RN S stated, I was called by a different nurse and went in to check on (Resident #47). (Resident #47) was so upset RN S was asked how they knew the Resident was upset and replied that they were crying out. RN S continued, Visibly upset and scared. (Resident #47) said they didn't want (CNA U) in there (room) anymore. When asked what they did after checking on Resident #47, RN S stated, It took a while to calm (Resident #47) down. RN S revealed they exited Resident #47's room after calming them and then called the Administrator. RN S explained that after contacting the Administrator, they located CNA U and sent them home. When queried regarding CNA U's response, RN S stated, (CNA U) was upset and yelled. When asked if they had ever observed CNA U providing resident care or had any concerns related to their work performance and/or interactions prior to the incident, RN S revealed they had not observed them providing care but were aware of CNA U inappropriately verbalizing disgruntlement related to assignments in the past. When asked if they recalled who the nurse was that called to notify them of the incident, RN S revealed they believed it was LPN C. An interview was completed with LPN C on 3/12/24 03:38 PM. When queried regarding the incident on 2/2/24, LPN C stated, I was not in the room. When asked what happened, LPN C revealed CNA T brought the situation to their attention and they reported it to the RN Supervisor. When asked where CNA U was when CNA T informed them of what had occurred, LPN C replied, I think they were in the break room. LPN C was asked if they immediately notified RN S and stated, I went and checked on (Resident #47) right away and then called. When queried regarding Resident #47, LPN C stated, (Resident #47) was flustered. It took reassurance to calm them. An interview was conducted with the DON on 3/13/24 at 2:37 PM. When queried regarding staff interviews and statements indicating the Resident experienced psychosocial distress following the incident of verbal abuse on 2/2/24, the DON confirmed but did not provide further explanation. The DON specified the facility determined the verbal abuse had occurred and was unacceptable. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy/procedure entitled, Abuse, Neglect and Exploitation Policy (Revised: 5/24/23) revealed, It is the policy . to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . The facility must: 1. Not use verbal, mental . abuse . Prevention of Abuse, Neglect, and Exploitation - The facility will consider utilization of the following tips for prevention of abuse . j. Supervise staff to identify inappropriate behaviors, such as using derogatory language, rough handling, or ignoring residents while giving care . k. Assess, monitor, and develop appropriate plans of care for residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors, residents with communication disorders and those that require heavy nursing care and/or are totally dependent on staff . Investigation of Alleged Abuse, Neglect and Exploitation - When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted . a. Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. b. If there is no discernable response from the resident, or if the resident's response is incongruent with that of a reasonable person, interview the resident's family, responsible parties, or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident. c. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement .

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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** 22927 Based on interview and record review, the facility 1) Failed to document abdominal/bowel assessment and treatment for a change of condition for one resident (Resident #279) and 2) Failed to thoroughly assess a resident with new onset pain and swelling, notify the physician and provide timely interventions for one resident (Resident #18) resulting in the likelihood for missed identification and assessment of changes in condition and delays in treatment. Findings include: Record review of the facility 'Pain Assessment and Management Protocol' policy dated 12/27/2023 revealed the facility must ensure that pain management is provided to residents who require such services, consistent with professional stands of practice, the comprehensive person-centered care plan, and the residents goal and preferences. The facility utilizes a systematic approach for recognition, assessment, treatment, and monitoring of pain. (2.) Behavioral signs and symptoms that may suggest the presence of pain include but are not limited to: Change of gait, loss of function, decline in activity level, resisting care, Bracing/guarding/or rubbing, fidgeting, increased or recurring restlessness, facial expressions/grimacing/frown/clinching of jaw, change in behavior/depressed mood/decreased participation in usual activities of daily living, difficulty eating or loss of appetite, sighing, groaning, crying, whimpering, breathing heavily or screaming. Record review of the facility 'Acute Change in Condition' policy dated 1/24/2024 revealed that it was the policy of the facility to recognize, diagnosis, treat, and monitor residents for an acute change of condition. the licensed nursing staff will notify the resident's attending physician or the physician on call when there has been a significant change in the resident's physical/emotional/mental condition . The licensed Nursing staff and/or Interdisciplinary team members will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Resident #279: Record review of Resident #279's Minimum Data Set (MDS) dated [DATE] revealed an elderly resident. Section C: Cognitive patterns revealed moderately impaired cognitively with decisions poor, cues/supervision required, inattention-behavior present fluctuations (comes and goes) changes in severity. Disorganized thinking functional. Section GG: Functional abilities revealed total dependence on staff for: bathing, upper/lower body dressing, mobility of rolling left and right, sit to lying, lying to sitting, sit to stand, and chair to bed. Section I: Active diagnoses revealed coronary artery disease, heart failure, orthostatic hypertension, gastroesophageal reflux disease, diabetes, Alzheimer's disease, dementia, malnutrition, and anxiety were noted. Section H: Bowel and Bladder revealed that the Resident #279 was always incontinence of bladder and bowel. Record review of Resident #279's August 2023 Medication Administration Record (MAR) revealed that the resident received Fleet (sodium phosphate) enema 19-7gm/118ml rectal enemas as needed if no bowel movement X 4 days. Certified nurse assistant may administer and nurses to monitor for results was given on 8/21/2023 and on 8/22/2023. Dulcolax 10mg suppository rectal as needed if no bowel movement X 3 days was given on 8/25/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #279's electronic medical record revealed that progress notes on 8/18/23 at 9:34 PM by the physician assistant (PA) refilled pain medication for chronic low back pain without sciatica was noted. The next progress note was not until 8/23/2023 at 1:12 PM by the wound care nurse described the stage III coccyx wound. There were no progress notes or assessments of abdominal bowel sounds or abdominal distention related to the administration of Fleet enemas that were given to the resident. Record review of Resident #279's electronic medical record tab 'Observation Assessments' revealed that the last 'Bowel & Bladder' assessment was on 6/13/2023 at 10:32 AM. in an interview and record reveal on 03/13/24 at 09:56 AM with the Director of Nursing (DON) revealed that the incident for Resident #279's Injury of unknown origin identified on 8/26/2023, was investigated by DON and Nursing Home Administrator (NHA). The DON stated that the investigation looked back to 8/23/2023 and went forward from that date. Record review of the resident progress notes revealed no notes from 8/18/2023 till 8/23/2023. they did not investigate the days of 8/19/23, 8/20/23, 8/21/23 and 8/22/23 when the resident received fleet enemas both days and there were no abdominal/bowel assessments found. Record review of resident August MAR TAR revealed fleet enemas given on 8/21/23 and on 8/22/23, with no nurse assessment documented. The DON stated that there should have been a nursing documentation on assessment of bowels/abdominal sound/distention. 49944 Resident #18: On 03/11/24, record review revealed that resident #18 was [AGE] years old, admitted to the facility on [DATE] and is currently on hospice care. Resident #18 has diagnoses of muscle weakness, major depressive disorder, generalized anxiety disorder, age-related osteoporosis without current pathological fracture and vitamin d deficiency. Resident #18 is dependent on staff for transfers in a maxi-lift. On 03/13/24, record review of the facility reported incident (FRI) investigation revealed that on Feb. 7th 2024 Resident #18 received an x-ray after having complaints of right knee and right hip. X-ray revealed a questionable femoral neck fracture with impaction and suggested a repeat x-ray or Computed Tomography (CT) scan. The Physician Assistant (PA) was notified of the possible fracture and ordered resident be sent to the emergency room for follow up to confirm x-ray results. Follow up results revealed a right femoral neck fracture. PA and power of attorney (POA) were notified of the x-ray results. On 03/13/24, record review revealed a progress note dated 02/03/24 at 11:00 AM entered as a late entry on 02/13/24 at 05:54 PM. The progress note reads: res complaining of pain to right knee. Found knee slightly swelled and warmer to touch than left knee. No redness or discoloration. Applied ice to help swelling and elevated leg on a pillow. On 03/13/24, record review revealed a progress note dated 02/03/24 at 15:39 PM that read: Resident was crying in a lot of pain PRN morphine given as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24, record review revealed a progress note dated 02/06/24 at 11:16 AM reads: resident complaining of right knee pain. Knee with no redness or warmth noted. Slight swelling with no edema. Resident received routine pain medications at this time and ice pack. On 03/13/24, record review of the FRI investigation revealed on 02/06/24 CNA 'A' went to RN 'A' and LPN 'A' and said resident was complaining of pain to her knee. RN 'A' and LPN 'A' noted a little swelling noted, no redness, no bruising, no shortening or rotation noted. First made aware on 02/06/24. CNA 'A' witness statement in FRI packet stated that Resident #18 had been complaining of pain on Feb. 3rd, 4th, 6th and 7th. CNA made nursing aware on 2/3/24 of pain. On 03/13/24, record review of the FRI investigation revealed a written witness statement from CNA 'A' on 02/03/24 that reads: I came in at AM checked resident #18 and she was dry. Went back to check her at 10 am and took her blankets all the way off and noticed her leg was swollen and warm to the touch. So I got the nurse to look at it and the nurse put an ice pack on it. resident #18 screamed and cried when I had to roll her and she begged me not to move her. At 2pm CNA 'A' had to get the nurse to look at resident #18's leg and the nurse helped CNA 'A' change her and resident #18 cried in pain. On 03/13/24, record review of the FRI investigation revealed a written witness's statement from CNA 'A' on 02/04/24 reads: I came in at 7am, checked resident #18 around 7:30AM. Resident #18 screamed and cried begging me not to move her because her leg hurt, R18 had an ice pack on the leg. On 03/13/24, record review of the FRI investigation revealed a written witness statement from CNA 'A' on 02/06/24 reads: I came in at 7am, checked resident #18 around 7:30AM resident #18 cried and begged me not to touch her because her leg hurt so bad. CNA 'A' went the nurse providing care for resident #18 letting them know resident #18 was still in a lot of pain and wouldn't let CNA 'A' do anything. On 03/13/24, record review of the FRI investigation revealed a written witness statement from CNA 'A' on 02/07/24 reads: I came in at 7am resident #18 was crying in pain. CNA 'A' told the nurse who said they had given resident #18 pain meds. CNA 'A' went in to change resident #18 and again resident #18 begged her not to change her or move her because her leg hurt. CNA 'A' noted that resident #18 continued to scream in pain and CNA 'A' went to the nurse to let them know resident #18 was still in a lot of pain, an ice pack was applied and CNA 'A' was informed that an x-ray was being ordered for resident #18. On 03/13/24 record review of the electronic health record progress notes from 02/01/24 to 02/05/24 for resident #18 revealed that nursing staff had documented an increase in pain and crying, but there were no progress notes stating the physician was notified of the increase in pain or crying. On 03/13/24 record review of the facility policy Acute Change in Condition, revised 01/24/24, under Procedures: The licensed nursing staff will notify the resident's attending physician or the physician on call when there has been: -A significant change in the resident's physical/emotional/mental condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay County Medical Care Facility	564 W Hampton Road Essexville, MI 48732

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 01:25 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked why wouldn't one of the nursing staff notify the physician of an increase in pain or order an x-ray sooner with the resident exhibiting new onset pain in her knee. The DON states that she gives the nurses autonomy to make decisions and use nursing judgement for resident care. The DON did not have an answer for why an x-ray wasn't ordered or why the physician wasn't notified of the change sooner. The DON stated the staff continued to medicate the resident for pain along the way but again did not know why an x-ray wasn't ordered sooner. On 03/13/24 record review of the February 2024 medication administration record revealed that resident #18 was taking Morphine 30 mg extended release twice daily until 02/09/24. On 02/10/24 the morphine order was changed to 30 mg three times a day to address the increase in pain. Resident #18 readmitted to the facility on [DATE] as a non-surgical candidate with a hip fracture. There was no evidence that the pain medication regimen had been addressed while the resident was experiencing new onset pain that limited her ability to complete activities of daily living.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 22927 Based on observation, interview and record review, the facility failed to adequately supervise and prevent injuries/falls for three residents (Resident #7, Resident #18, Resident #279), resulting in multiple injuries of residents and prolonged illness and hospitalization s. Findings included: Record review of the facility 'Compliance with Reporting Allegations of Abuse/Neglect/Exploitation' policy dated 3/30/2023 revealed it is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the administrator of the facility and to other appropriate agencies. Injuries of unknown source: Includes circumstances when both the following conditions are met. (i.) The source of the injury was not observed by any person or could not be explained by the resident. (ii.) The injury is suspicious because of the extent of the injury, location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. Resident #279: Injury of Unknown origin: Record review of Resident #279's Minimum Data Set (MDS) dated [DATE] revealed an elderly resident. Section C: Cognitive patterns revealed moderately impaired cognitively with decisions poor, cues/supervision required, inattention-behavior present fluctuations (comes and goes) changes in severity. Disorganized thinking functional. Section GG: Functional abilities revealed total dependence on staff for: bathing, upper/lower body dressing, mobility of rolling left and right, sit to lying, lying to sitting, sit to stand, and chair to bed. Section I: Active diagnoses revealed coronary artery disease, heart failure, orthostatic hypertension, gastroesophageal reflux disease, diabetes, Alzheimer's disease, dementia, malnutrition, and anxiety were noted. There was no mention of osteoporosis (weakening of the bones). Record review of Resident #279's electronic medical record, Continuity of Care' document revealed there was no osteoporosis diagnosis. Record review of the facility incident report (FRI) noted that on 8/26/2023 at approximately 10:00 AM Resident #279 was noted to have left leg shortening and rotation of the leg. Record review of the facility Resident #279 investigation file of injury of unknown origin revealed that a commuted intertrochanteric acute Fractured of the left hip. Record review of the FRI documents. In an interview and record reveal on 03/13/24 at 09:56 AM with the Director of Nursing (DON) revealed that the incident for Resident #279's Injury of unknown origin identified on 8/26/2023, was investigated by DON and Nursing Home Administrator (NHA). The DON stated that the investigation looked back to 8/23/2023 and went forward from that date. The DON stated that the investigation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Summary was that there was no wrongdoing, and that the medical director did state that the fracture may have happened as a spontaneous fracture. The DON reviewed the medical record with the state survey and acknowledged that there was no medical diagnosis for osteoporosis for the resident. Record review of Resident #279's hospital Computed Tomography (CT) scan report dated 8/26/2023 revealed a comminuted intertrochanteric acute fracture of left hip with mild-to-moderate fragment separation. Findings: Again, seen is a comminuted and moderately displaced intertrochanteric fracture of the proximal left femur. Fracture appears be superimposed on marked bone demineralization. No clear lytic or blastic bone lesion is this region to definitively indicate a pathological fracture . 37668 Resident #58: On 3/11/24 at 11:43 AM, Resident #58 was not in their room. An observation of their room was completed at this time. Anti-slip strips were observed on the floor next the Resident's bed. Record review revealed Resident #58 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease, dementia, weakness, and repeated falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent/required maximum assistance for transferring, hygiene, and mobility. Review of Resident #58's Electronic Medical Record (EMR) revealed a Safety Events-Falls report, dated 2/22/24, which detailed Resident #58 had a witnessed fall in their room. The Event Summary specified, Probable/Possible cause of fall: Care plan not followed. Resident leaned too far forward while sitting at the edge of the bed. Was the Care Plan followed: No . Aide did not follow care plan which stated Resident is to be transferred as a two assist with gait belt and walker for support . The event indicated Certified Nursing Assistant (CNA) W was the only witness to the incident. Review of progress note documentation in Resident #58's EMR revealed the following: - 2/22/24 at 4:20 PM: This nurse entered room after being told that Resident was lowered to the floor. Upon entering resident's room, resident was laying alongside bed with bilateral arms in lap and legs extended out. Prior to being lowered, resident's aide changed brief and put on pants after providing care to get resident up for dinner. Aide sat resident up at the edge of the bed to place gait belt as resident began to lean forward . lowered resident to the floor . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- 2/23/24 at 9:21 AM: On 2/22/24 During an attempt to transfer resident from bed into wheelchair the CNA sat the resident up on the edge of bed and was attempting to apply gait belt when the resident began to lean forward sliding out of the bed. The CNA was unable to support the resident's weight to place back into bed, and slowly guided to a lying position on the floor along the right side of bed. The CNA then utilized the staff emergency call light to alert the nurse . licensed staff was called to resident's room regarding a fall. Upon entering residents' room, observed (Resident #58) lying on the floor along the right side of bed. Resident was positioned with head towards the head of bed with bilateral legs extended straight out towards the foot of bed. Resident's walker was positioned along the right side of them . No pain or injury noted . At time of incident the CNA stated . had sat resident up at the side of her bed in an attempt to apply gait belt for a 1 assist transfer when the resident began to lean forward causing (Resident #58) to begin sliding out bed. CNA was unable to support resident's weight to reposition back into bed, so then guided (Resident #58) to a safe position on the floor and alerted the nurse. Resident is care planned for 2-assist with walker for support for all transfers. CNA was counseled . PT (Physical Therapy) referral sent . Resident placed on 3-day monitoring r/t fall and self-transfers. Review of Resident #58's Electronic Medical Record (EMR) revealed a care plan entitled, Mobility: I am unsteady and have generalized weakness, so I need assist with transferring and walking. I have c/o (complaints of) vertigo (dizziness) with noted orthostatic hypotension episodes (decrease in blood pressure with change in position). I have had falls at this facility & history of falls at home . I have impaired cognition and may not always ask for assistance (Start: 9/18/20; Reviewed/Revised: 3/1/24). The care plan included the interventions: - I transfer to/from the bed & w/c (wheelchair) with max assist of 2 with walker (Start Date: 10/11/22) - I require assistance for turning and repositioning in bed (Start Date: 9/18/20) An interview was completed with the facility Administrator on 3/12/24 at 11:48 AM. When queried regarding Resident #58's fall, the Administrator revealed CNA W attempted to transfer Resident #58 with one assist, was unable, and lowered the Resident to the floor. When asked, the Administrator stated, (CNA W) will be here at 3:00 PM for work. An interview was completed with CNA W on 3/12/24 at 3:47 PM. When queried if they were assigned to care for Resident #58's on 2/22/24, CNA W confirmed they were. When queried if they were transferring the Resident by themselves and had to lower the Resident to the floor, CNA W confirmed. CNA W was asked what had occurred and stated, I never get help. I put my staff call light on (to request assistance with the transfer) and revealed no one responded. When asked how long they waited, CNA W replied, Maybe five to ten minutes. CNA W revealed the Resident was sitting up, ready to be transferred, and was becoming antsy waiting for another staff member to respond. CNA W revealed they proceeded to attempt to transfer the Resident by themselves and had to lower them to the floor. CNA W stated, I own it. (Resident #58) was a two assist and I should have waited. A demonstration of the transfer and how the Resident was lowered to the floor was completed at this time. When asked what happened after the Resident was on the floor, CNA W indicated the staff assistance call light was still on and no one had responded so they made sure the Resident was okay and exited the room to look for assistance. When queried how long it took to locate another staff member for assistance, CNA W stated, The nurse was at the cart, not even 20 feet away from the room. CNA W then stated, My assist light was still on and reiterated no staff had responded. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 3/12/24 at 4:10 PM. When queried if all staff are responsible/expected to respond to staff assistance call lights, the DON verbalized they were. When queried regarding Resident #58 being lowered to the floor on 2/22/24, the DON revealed CNA W had attempted to transfer the Resident with one assist when the Resident was care planned for two-assist. The DON was then queried regarding CNA W stating no one had responded to their staff assist light and the nurse being outside of the room, the DON indicated they were unaware and would address. 49944 Resident #7: On 03/11/24 record review revealed that resident #7 was [AGE] years old and admitted to the facility on [DATE] and still resides in the facility. Resident #7 has a brief interview for mental status (BIMS) score of 5 indicating severe impairment of their mentation. Resident #7 has diagnoses of Alzheimer, dementia, muscle weakness, unsteadiness on feet, abnormalities of gait, history of falling and anxiety. On 03/11/24, record review of a Facility Reported Incident (FRI) investigation provided by the facility revealed that Resident #7 fell and sustained a fracture on 02/29/24 and currently is on 1:1 monitoring for safety at this time. On 03/12/24, record review of the summary of the FRI investigation from 02/29/24, revealed that resident #7 was in her wheelchair at the nurse's cart at approximately 07:32 PM on 02/29/24 with the nurse present and sustained a fall at 07:35 PM. On 03/12/24, record review of the FRI investigation timeline revealed that on 02/29/24 at 7:10 PM CNA 'A' transferred resident #7 from her bed to her wheelchair because they noted resident #7 to be attempting to self transfer out of bed. CNA 'A' then took the resident to the nurse's med cart so they could go to break. At 7:32 PM on 02/29/24 LPN 'A' and activity aide (AA) 'A' assisted Resident #7 back to a seated position in her wheelchair, LPN 'A' then took resident #7 back to the nurses med cart where another nurse was present and preparing medications for medication pass. At 7:35 PM resident #7 was observed on the floor in the hallway of the second floor. On 03/12/24 at 12:30 PM an interview was conducted with the Director of Nursing (DON), the DON was asked if Resident #7 had someone with them at the time of the fall and if they were being supervised since it seemed the resident was anxious and was attempting to self transfer from bed prior to the fall. The DON stated that LPN 'B' was present with resident #7 at his medication cart and was preparing medications for other residents The DON then stated that LPN 'B' then went into another residents room to administer medications, at this time resident #7 self-propelled in her wheelchair off the hallway as she usually does and out of sight of staff and sustained a fall. The DON was asked again if the resident was being supervised at the time of the fall and they said no. The DON was asked if the resident should've been supervised since her BIMS was 5 and she said yes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/12/24 at 12:45 PM an interview was conducted with the restorative nurse, the restorative nurse was asked if resident #7 had any prior falls in the facility, they stated that resident #7 had a fall on 01/23/24 and that was the first time they knew the resident to stand up from her wheelchair prior to the fall on 02/29/24. The restorative nurse was asked if the resident should be supervised when out of bed based on her BIMS of 5, they replied they didn't believe the resident needed to be supervised at all times. Restorative nurse stated the resident usually got around the facility on their own in their wheelchair. On 03/12/24 at 12:51 PM an attempt was made to contact LPN 'B', LPN 'B' did not answer the phone and never called back to complete the interview. On 03/12/24 at 03:38 PM, an interview was conducted with AA 'A' about Resident #7's recent fall with fracture. AA 'A' was asked what their involvement was in the lead up to the fall. AA 'A' stated that they were leaving an activity in the 2nd floor recreation room, AA 'A' said they were taking another resident back to their room from the activity when they noticed resident #7 looking worked up in the hallway by 2 west. AA 'A' said resident #7 gets worked up at night time and can become anxious. After AA 'A returned the resident from the activity to their room and as they were heading back to the recreation room to get another resident, AA 'A' noted resident #7 to be standing in an alcove area between the east and west hall. AA 'A' stated that the resident was by herself when she discovered her standing. AA 'A' assisted the resident to sit down in her chair and AA 'A' stated LPN 'A' was there to help as well. AA 'A' stated at that point LPN 'A' was with the resident and she went back to work. On 03/13/24 at 02:17 PM an interview was conducted with LPN 'A', LPN 'A' was asked about her involvement in resident #7's fall with fracture. LPN 'A' stated that they transported resident #7 down towards her room on the west hall after assisting AA 'A' to get resident #7 seated in her wheelchair and placed her at the medication cart with LPN 'B'. LPN 'A' stated that LPN 'B' was present at the medication cart at the time resident #7 was placed there.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 39059 Based on observation, interview and record review, the facility failed to properly label and date an Intravenous (IV) medication for one (Resident #32), resulting in the lack of date and time of administration with the likelihood of reuse of IV tubing and/or wrong administration times. Findings include. On 3/11/24, at 4:19 PM, Resident #32 was resting in their bed. There was an intravenous (IV) bag with tubing hanging from an IV pole hooked to an IV pump. There was no date nor time of administration written/labeled on the IV bag. On 3/11/24, at 4:40 PM, a record review of Resident #32's electronic medical record revealed an admission on 11/17/2021 with diagnoses that included bloodstream infection, Sepsis due to Methicillin susceptible Staphylococcus aureus. Resident #32 had intact cognition and required assistance with Activities of Daily Living. A review of the Physicians orders revealed cefazolin recon soln; 2 gram; amt 2 gram; intravenous Special Instructions: Pharmacy to dose r/t sepsis, Every 8 hours 06:00, 14:00, 22:00 Start Date 02/14/2024 On 3/12/24, at 9:15 AM, Resident #32 was resting in their bed. The IV bag/tubing was hanging from the IV pole. There was no date labeled/written on the IV bag nor the tubing. On 3/12/24, at 3:57 PM, Resident #32 was resting in their bed. The IV antibiotic Cefazolin was hooked to the IV pump and was being administered into their right arm. There was no date nor time labeled/written on the bag. The tubing was not dated. On 3/12/24, at 4:00 PM, Nurse L was asked if they administered the IV antibiotic to Resident #32 and Nurse L stated, I hung it a 1529 (3:29 PM). On 3/12/24, at 4:05 PM, Nurse I entered Resident #32's room and was asked if the IV antibiotic bag had a date and time on it and Nurse I stated, No. Nurse I was asked to provide the facility policy on administration of IV medications. On 3/12/24, at 4:19 PM, a record review along with Nurse I of the facility provided Documentation of I.V. Therapy Reviewed: 12/27/23 policy revealed . All I.V. medications and fluids will be initialed, dated, and timed by the qualified nurse hanging the infusion .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize procedures to ensure accurate documentation, reconciliation, and oversight of controlled drugs in one (Two East) of six medication carts resulting in inaccurate narcotic medication documentation and reconciliation. Findings include: On 3/12/24 at 3:55 PM, a tour of the Two East Medication Cart including narcotic medication reconciliation was completed with Registered Nurse (RN) X. The narcotic medication count sheet for Resident #14's Hydromorphone 1 mg (milligram)/mL (milliliter) did not correlate with the amount of Hydromorphone present in the bottle. The sheet indicated there should be 85 mL and the bottle was noted to have greater than 100 mL. When asked, RN X confirmed the amount of medication in the bottle did not correlate with the amount that was supposed to be present per the narcotic medication count/administration record. Further review revealed each staff member had documented they administered 5 mg each dose when the ordered amount for administration was 0.5 mg. Additionally, nursing staff had documented 100 mL as the amount of narcotic medication remaining in the bottle on two separate occasions after having documented the medication as being administered. An interview and documentation review was completed with the Director of Nursing (DON) on 3/12/24 at 5:08 PM. The DON was shown the Hydromorphone 1 mg/mL narcotic medication reconciliation/administration sheet and asked what to identify the concern. The DON stated, 100 mL twice. When queried regarding the amount of medication documented as administered vs the ordered amount, the DON immediately identified staff were not documenting the correct dosage on the form but were documenting the correct dose in the Electronic Medical Record. The DON was notified regarding the amount of medication in the bottle being more than what was documented as should be present on the form and verbalized all staff had documented five instead of 0.5. The DON verbalized understanding of concern and stated they would address immediately. When queried regarding oversight of narcotic medications, the DON revealed Unit Managers are supposed to audit the sheets for accuracy and to ensure there are no discrepancies in narcotic administration and that nursing staff complete a count at each shift change. Review of facility provided policy/procedure entitled, Controlled Substance and Narcotic Count (Revised 9/27/23) revealed, Facility promotes safe, high quality patient care, compliant with . regulations regarding monitoring the use of controlled substances . 2. Medication Administration and Accountability by Nurses . c. All controlled substances . must be accounted for at the beginning and the end of each shift, jointly by the nurse coming on and going off [NAME]. i These counts will be verified by the signature of both nurses .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to follow policies and procedures for medication labeling and storage in 3 of 3 Medication carts reviewed, 1 of 2 Medication rooms reviewed and narcotic reconciliation, resulting in opened and undated multi-dose medications, and the disposal of expired medications and altered medication efficiency with the likelihood of misappropriation going unnoticed. Findings include: Record review of the facility 'Administration of Medications' policy dated 10/25/2023 revealed the facility ensures medications are administered by licensed nurses as ordered by the physicians and in accordance with professional standards, in a manner to prevent contamination or infection. Record review of the Center of Disease Control (CDC) https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html Medication vials should always be discarded whenever sterility is compromised or cannot be confirmed. In addition, the United States Pharmacopeia (USP) General Chapter 797 [16] recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Observation and interview on 03/12/24 at 03:35 PM with Licensed Practical Nurse (LPN) B of the 1 East south unit medication cart teens cart. Observation of the 1 East south medication cart revealed Resident #63's Flonase nasal spray 50mcg open and not dated. Resident #12's Flonase 50mcg spray opened and not dated. also, Albuterol sulfate inhaler 90mcg not dated open 198 puffs noted on dial. Observation and interview on 03/12/24 at 03:48 PM with Licensed Practical Nurse (LPN) C of the 1 East north unit medication cart revealed Resident #27's multi-dose bottle of Ferrous Sulfate liquid bottle came with 473 milliliters (ml), currently has 300ML, no open date noted on bottle. LPN C looked on all side of the bottle with no open date found. Observation of Resident #68's budesonide 0.5mg/2ML. nebulizer treatment ampules noted two foil packets opened and not dated, one loose vial was found in the brown zip lock bag not in a dispensing package and unlabeled. Observation of Resident #17's Atropine 1% eye drop for secretions the bottle was opened and not dated. Observation of Resident #62's Haldol 5mg/ML injectable 3 vials and one without the green sealed cap found in a clear plastic bag lying at the back of the medication cart in the top drawer. Observation and interview on 03/13/24 at 08:31 AM of the 1East Medication room with Registered Nurse (RN) A of the medication room refrigerator revealed a single (continued on next page)

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	235044	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay County Medical Care Facility	564 W Hampton Road Essexville, MI 48732

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Aplisol 1ml (10 test per bottle) injectable with top opened with no open date documented on bottle or plastic bag. RN A stated that it should have been dated when first used and threw out the bottle. 37668 On 3/12/24 at 3:55 PM, a tour of the Two East Medication Cart was completed with Registered Nurse (RN) X. The following items were present in the cart: - Evencare Blood Glucose Test Strips, Opened and Undated. When asked how long blood glucose testing strips are able to be used for after opened, RN X stated, 60 days. - Ipratropium Bromide 0.5 milligrams (mg) and Albuterol Sulfate 3 mg/3 milliliter (mL) inhalation solution (Douneb treatment) vials for Resident #16. The foil container was open and undated and there were two loose vials in the bottom of the box. - Ipratropium Bromide 0.5mg and Albuterol Sulfate 3 mg/3 milliliter (mL) inhalation solution vials for Resident #32. The foil container was open and undated and there was two loose vials in a separate box. When asked how long Ipratropium Bromide 0.5 mg and Albuterol Sulfate Inhalation 3 mg/3 milliliter (mL) inhalation solution is good for after being opened, RN X revealed they did not know. When queried if the medication information insert in the box contained the information, RN X reviewed the document and stated, One week once foil (package) opened. - Fluticasone Furoate/Vilanterol Ellipta 200 mcg (microgram)/ 25 mcg inhaler for Resident #32, opened and undated. When asked how long the medication is able to be used for after opened, RN X reviewed the medication information insert and stated, 6 weeks. - Albuterol Sulfate 0.63mg/3mL inhalation solution for Resident #51, foil package open and undated. - 10-inch winged infusion set (Huber needle) with 22-gauge (g) X 0.75 inch needed; Expired: 12/31/23. When queried, RN X revealed a Resident was currently using the needles for infusion treatments. - Novolin R Insulin 100 U (units) vial for Resident #24. The vial was dated as opened on 2/19/24 and expired on 4/1/24. When queried how long Novolin insulin is able to be used for after opened, RN X indicated they thought it was 30 days. When queried regarding the expiration date of 4/1/24, RN X was unable to provide an explanation. - Carboxymethylcellulose sodium 0.5% eye drops for Resident #14, open and undated. - Olopatadine 0.1% eye drop vial for Resident #28, Opened and undated. - Carboxymethylcellulose sodium 0.5% eye drops for Resident #51, open and undated. - Olopatadine 0.1% eye drop vial for Resident #51, Dated as opened on 1/30/24 and expired on 2/27/24. When asked, RN X confirmed Resident #51 was currently receiving the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Atropine 1% drops for Resident #14, Opened and undated - Alphagan P 0.1% eye drops, 5 mL vial for Resident #24. Open and undated. An interview and documentation review was completed with the Director of Nursing (DON) on 3/12/24 at 5:08 PM. When queried regarding open, undated, and expired medications and medical supplies in the Two East Medication Cart, the DON verbalized medications should be dated when opened and disposed appropriately. The DON indicated they would address the concerns. 39059 On 3/12/24, at 9:00 AM, During medication administration task, a record review of the Sign In and Out Sheet for Narcotics with Nurse L revealed only 4 columns. There was a column for Date Time Outgoing Nurse Incoming Nurse. Nurse L was asked what the signatures on the sheet meant and Nurse L explained that the incoming nurse looks at the actual narcotics and the outgoing nurse looks at the orange sheets and then both nurses sign that they match. Nurse L was asked how they keep track of newly delivered narcotic cartridges and Nurse L stated, we just match what's in the drawer to the orange sheets. On 3/13/24, at 11:40 AM, the Director of Nursing (DON) was interviewed regarding the Narcotic reconciliation process in the facility. The DON explained when the Narcotics are delivered from the pharmacy each cartridge of narcotics are wrapped in an orange narcotic sheet. The narcotic gets placed into the locked drawer in the medication cart and the orange sheet gets placed in the narcotic binder on top of the cart. Once the narcotic is destroyed or completed, the orange sheets get placed in a mailbox and then stored in medical records. The DON offered that two nurses destroy narcotics and place them in the drug buster. The DON explained they do not have a part of it and stated the Quality Nurse M managed the process. On 3/13/24, at 11:50 AM, the Quality Nurse (QN) M was interviewed regarding the facility process on narcotic reconciliation. QN M offered that the narcotics get delivered and two nurses sign them in to the appropriate cart. QN M explained the nurses reconcile at shift change with the orange narcotic sheets to ensure the quantities match. QN M offered that they are never present when narcotics are delivered as they are delivered at night time. QN M stated, we used to audit but had been compliant for quite some time so we stopped but then began auditing two to three months ago. QN M was asked how they would recognize if a narcotic cartridge and the orange sheet for that cartridge went missing how would they know. QN M offered that was why they began the auditing again. QN M was asked if there was discrepancies and QN M stated, there was discrepancies on the count; it was either the medication was given and not charted or the other way around. QN M further offered that they had discussed with a new employee/nurse that they may change the narcotic reconciliation process to add the total number of cartridges to the count sheets rather than just the two nurse signatures. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/12/24, at 1:30 PM, a record review of the facility provided policy Controlled Substance & Narcotic Count Revised: 9/27/23 revealed . Medication Administration and Accountability by Nurses a. The nurse administering a controlled substance will immediately sign out each dose of medication after it is removed from the locked drawer in the proof of use sheets and administered. NOTE: The medication is also signed out on the residents EMAR. b. After completion, Proof of Use Sheets are restored in the facility for a period of at least 2 years. c. All controlled substances locked in the double lock cavinet or drawers, or any refrigerated substance [NAME] be accounted for at the beginning and the end of each shit, jointly by the nurse coming on and going off duty. i. These counts will be verified by the signature of both nurses on the shift inventory sheets . d. A count of number of pills will be completed with each count and noted on the Controlled Substances Shift Inventory Sheet. i. Nurses will add number of new cards containing controlled substances with each deliver. ii. All nurses will subtract completed cards removed . The facility did not provide the Controlled Substances Shift Inventory Sheet nor was this document located in the binder atop the medication carts.