STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235050	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36221 Based on observation, interview, and record review, the facility failed to ensure timely care and services to promote dignity and ensure a dignified environment during meal times in 3 of 5 residents (Resident #10, #331, & #6) reviewed for dignity/respect, resulting in long call light wait times with incontinence, meals left in front of a resident without timely assistance provided, and the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Review of the policy/procedure Promoting/Maintaining Resident Dignity, dated 3/5/24, revealed .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality .All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights .Respond to requests for assistance in a timely manner . Resident #10 Review of an Admission Record revealed Resident #10 was a female, with pertinent diagnoses which included back pain, stroke with right sided weakness, diabetes, arthritis, depression, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #10, with a reference date of 4/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of a current Care Plan for Resident #10 revealed the focus .I have an ADL (Activities of Daily Living) deficit and need assistance with daily care r/t (related to) weakness Impaired balance, Impaired Gait, Impaired mobility, Weakness / Debility . revised 12/12/23, with interventions which included .ADL care to meet my needs . initiated 7/23/23. In an interview on 5/21/24 at 1:38 PM, Resident #10 reported issues with long call light wait times at the facility, and stated .Sometimes I have to wait an hour for them to get me to the bathroom . Resident #10 reported she has experienced bowel incontinence due to long wait times, and stated .I feel bad about it. As though, like I'm nothing . (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47955 Resident #331 Review of an Admission Record revealed Resident #331 had pertinent diagnoses which included: fracture of unspecified part of neck of right femur, presence of right artificial hip joint, history of falling. Review of a Minimum Data Set (MDS) assessment for Resident #331, with a reference date of 5/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #331 was mildly cognitively impaired. In an interview on 5/21/24 at 11:47 AM., Family Member (FM) O reported that a couple of days ago when she arrived to visit Resident #331, Resident #331 told FM O that she needed to use the bathroom and she was waiting for help. FM O reported that the red light on the wall indicating the call light was turned on was lit, but FM O pushed the call light button again, requesting assistance to the bathroom for Resident #331. FM O reported that she waited with Resident #331's in her room for over 20 minutes for staff to respond to the call light. FM O reported that Resident #331 had an incontinent (no control over loss of urine or stool) episode of stool outside of her bathroom. FM O reported that Resident #331 was angry and embarrassed after the incontinent episode. During an observation on 5/21/24 at 4:20 PM., Certified Nursing Assistant (CNA) GG requested assistance to answer call lights from CNA VV. CNA GG was overheard stating to CNA VV, . there are so many call lights on I can't answer them all myself . In an interview on 5/21/24 at 4:21 PM., CNA GG reported that there was one CNA and one nurse scheduled on each hall on the west unit. CNA GG reported that she did have to wait for another CNA to be available when a resident requires two people to assist them with care. CNA GG reported that when she had to wait for another staff member for assistance, it delayed being able to answer any call lights that were on during that time. In an interview on 5/21/24 at 4:27 PM., Resident #331 reported that she had been in the facility few days. Resident #331 reported she had a fall, she had broken her hip in the fall, and had come to the facility for rehabilitation. Resident #331 reported that she had a situation the other day when she had to wait more than 30 minutes for her call light to be answered. Resident #331 reported that because she waited so long for help, she had an incontinent episode of stool on the way to the bathroom when she did get help. Resident #331 reported that she was frustrated that she waited so long and embarrassed that she had an incontinent episode. In an interview on 5/22/24 at 8:19 AM., Registered Nurse (RN) XX reported that on the west unit, call lights do not display above the doors. RN XX reported that call light notifications go to a mobile phone the CNAs carry in their pocket and to a display screen at the nurses' station. RN XX reported that the nurses working on the floor do not get call light notifications. RN XX reported that when a CNA was busy with a resident, they are unable to communicate with other staff any call light notifications they received. RN XX reported the display screen was not visible to staff when they were away from the nurses station. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/22/24 at 2:55 PM., 3 nurses and 1 unit clerk were sitting at the west unit nurses station. The monitor that displays call light notifications showed 5 rooms had the call light activated, indicating that the residents in those rooms had requested assistance. In an interview on 5/23/24 at 8:00 AM., Licensed Practical Nurse (LPN) E reported that there was one CNA assigned to each of the three halls on the west unit. LPN E reported that the CNAs complete assigned showers and assist with meals as needed by the residents on their assigned halls. LPN E stated .it gets ugly when there is a call in and then the nurse will be called to help In an interview on 5/23/24 at 9:35 AM., Director of Nursing (DON) B reported that when a resident pushes the call light in their room, a notification was displayed on the screen at the nurses' station and the mobile phones were pinged. DON B reported that Quality Improvement Coordinator (QIC) D was the one that discovered that the phones don't always work. DON B reported that CNAs should carry the phones. DON B stated .but, staff don't use the phones. DON B reported that the call light notification system was not used on the nurse's tablets. DON B reported that CNAs should be doing rounds and the unit clerk should notify nurses when call lights are on. DON B reported that word of mouth was used on the unit when a resident needed assistance or was calling out for help. During an observation on 5/23/24 at 10:29 AM., 2 nurses and 1 unit clerk were sitting at the west unit nurses station. The monitor that displayed call light notifications showed 7 rooms had the call light activated, indicating the residents in those rooms had requested assistance. During an observation on 5/23/24 at 10:31 AM., a therapy staff member asked RN XX who was sitting at the west nurses station, if Resident #331's call light was on. RN XX replied Yes, it came on at 10:30 AM. During an observation on 5/23/24 at 10:34 AM., a visitor in Resident #331's room stated aloud .they will be here to get you . RN XX was observed walking down A hall on the west unit with a piece of paper in her hand and stated . so many lights are on! RN XX did not enter Resident #331's room. In an interview on 5/23/24 at 10:36 AM., CNA VV reported that she had a mobile phone in her pocket that call light notifications were supposed to go to. CNA VV reported that the phones disconnected frequently, and when the phone disconnected, the notifications did not go through. CNA VV reported that when there was an interruption in the internet connection the call light notifications did not work on the mobile phone. CNA VV reported that the phone would alarm and then required a reset, when that happened the call light notifications did not go through. In an observation on 5/23/24 at 10:37 AM., Resident #331's call light was answered. In an interview on 5/23/24 at 10:46 AM., QIC D reported that CNAs were the only staff that had phones for call light notifications and everyone could see the display screen for call light notifications at the nurses' station. QIC D reported that the CNAs were the only staff with access to the call light notifications. QIC D reported that nurses should help to answer call lights. 41424 Resident #6: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #6 was a male with pertinent diagnoses which included dementia, stroke, muscle weakness, dysphagia (damage to the brain responsible for production and comprehension of speech), pigmentary retinal dystrophy (rare, inherited disease causes the retina's light sensitive light cells to slowly break down leading to vision loss), repeated falls, anxiety, and monoplegia (complete or partial paralysis of a single limb). Review of current Care Plan for Resident #6, revised on 4/23/24, revealed the focus, .I have a nutritional problem r/t (related to) medical DX (diagnoses) .Legally blind .Receives altered textures, needs feeding assistance and cueing at meals, prefers finger foods at lunch/dinner . with the intervention .Supervision with meals .divided plate when not requiring assistance with feeding . During an observation on 05/21/24 at 03:58 PM, Resident #6 was observed lying in bed with blue wedges on his left side, supine position, bed was not low, fall mat next to bed, and resident was very odorous and had on a blue t-shirt with dried food on the upper chest area. During an observation on 05/21/24 at 12:55 PM, Resident #6 was lying in his bed and staff delivered his lunch, offered him a clothing protector, and placed his lunch on the rolling beside table. Observed at 05/21/24 at 01:00 PM, Resident #6's lunch tray was sitting on the rolling table. At 01:11 PM, Certified Nursing Assistant (CNA) L entered the room to provide assistance with Resident #6's lunch. In an interview on 05/23/24 at 08:59 AM, CNA Y reported those needed assistance with meals would receive their meal tray last. CNA Y reported the only resident who needed assistance with meals who eats on the unit was Resident #6 and he would receive assistance by his assigned CNA. In an interview on 05/23/24 at 09:27 AM, Quality Improvement Coordinator (QIC) D reported the meal tray for a resident who needs assistance would not be placed in the room and left. The resident who required assistance with meals would receive their meal tray and assistance with eating after all the other residents had received theirs on the unit.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to accommodate a resident's right to make choices that were consistent with their assessment and plan of care for 1 of 20 sampled residents (Resident #61) reviewed for resident choices, resulting in the resident not meeting their highest practicable level of well-being. Findings include: Resident #61: Review of an Admission Record revealed Resident #61 was a male with pertinent diagnoses which included stroke, dialysis, dementia, anxiety, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), aphasia (loss of the ability to understand or express speech caused by brain damage, like with a stroke), apraxia (neurological condition that makes it difficult or impossible to make certain movements), diabetes, and high blood pressure. In an interview on 05/22/24 at 08:10 AM, Resident #61 reported he only gets a shower once a week. He reported he was able to get up and go to the restroom to wash himself in the sink. Resident #61 reported he preferred to take a bath and had not been offered one while a resident. He reported he likes to take a bath to soak, it helped with his body pain. Review of the facility on 5/22/24 at 10:12 AM, this writer discovered there were two bath tubs on the rehabilitation side of the facility. In an interview on 05/22/24 at 01:08 PM, Family Member (FM) EEE reported she had spoken to Resident #61 and he had expressed to her he preferred to take a bath instead of a shower. In an interview on 05/23/24 at 08:34 AM, Certified Nursing Assistant (CNA) ZZ reported the CNAs would go by the resident's preference, some residents had a shower once a week, but most opt in for twice a week. When she bathed a resident she would ask the resident which one they preferred, a shower or a bath. CNA ZZ reported for those who were able to tell the aide which bathing preference, she would ask them. CNA ZZ reported for most residents she was aware of their preference for bathing, we know our residents. In an interview on 05/23/24 at 08:58 AM, CNA Y reported she would ask the resident what they preferred for bathing. CNA Y reported some residents preferred bed baths, some were able to take a bath on the bathing gurney. CNA Y reported when a resident would refuse, she would ask them again up to three times, and if they still refused she would let the nurse know and document on the shower sheet they completed for bathing. In an interview on 05/23/24 at 01:51 PM, CNA YY reported she asked the resident if they preferred a shower or bath. CNA YY reported it was documented on the kardex for the residents preferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Fundamentals of Nursing 9th edition by [NAME] & [NAME], Patients have individual preferences about when to perform hygiene and grooming care. Some patients prefer to shower, whereas other prefer to bathe. Patients select different hygiene and grooming products according to personal preferences. Knowing patient's personal preferences promotes individualized care. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME], Hall, Amy; Fundamentals of Nursing - E book (Kindle Locations: 50858-50860). Elsevier Health Sciences. Kindle Edition. According to Your Rights and Protections as a Nursing Home Resident revealed, .At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to .Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose . https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47955 This citation pertains to intake MI00144151 Based on interview and record review the facility failed to provide written notice of transfer for 1 (Resident #15) of 1 resident reviewed for hospitalization resulting in the potential for the resident and/or the resident's representative to be unaware of the resident's transfer out of the facility, the reason for the resident's transfer out of the facility, and/or the resident's rights. Findings include: Resident #15 Review of an Admission Record revealed Resident #15 had pertinent diagnoses which included: Type two diabetes mellitus without complications, bipolar disorder, and insomnia. Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 3/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #15 was cognitively intact. Review of Health Status Note for Resident #15 dated 4/19/24 at 11:41 AM., revealed .referral has been placed to (Name Omitted) hospital and has been accepted for admission today. Secured transport for 1300 . Review of Health Status Note for Resident #15 dated 4/19/24 at 13:28 PM., revealed . Resident left facility via wheelchair .report called to (Name Omitted) general voicemail box and message left . In an interview on 5/22/24 at 12:49 PM., Resident #15 reported that neither he nor his daughter received a notice for transfer before he transferred to (Name Omitted) hospital in mid-April. In an interview on 5/22/24 at 1:28 PM., Manager of Case Management (MCM) AAA reported that paperwork provided to a resident or their representative during a transfer included a medication list, face sheet, progress notes, and advance directives. In an interview on 5/22/24 at 3:01 PM., Registered Nurse (RN) XX, Unit Manager (UM) KK and RN X reported that the paperwork that accompanied a resident transfer out of the facility should include a face sheet, physician orders, MAR (medication administration record), E-interact transfer assessment form, advance directives, and if needed progress notes. The transferring nurse should also call report to the receiving hospital. In an interview on 5/22/24 at 3:08 PM., Director of Nursing (DON) B reported that the paperwork for a resident transfer to an acute care hospital should be a face sheet, medication list, and the transferring nurse should call report to the receiving hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/23/24 at 8:44 AM., MCM AAA reported that she did not know if nurses sent transfer notices with the resident when a resident was transferred to an acute care setting. In an interview on 5/23/24 at 8:49 AM., Medical Records Assistant (MRA) F reported that Resident #15 did not have a transfer notice in his electronic medical record from the transfer on April 19, 2024. In an interview on 5/23/24 at 9:48 AM., RN XX reported that she did not send a transfer notice with any resident that transfers out of the facility. RN XX reported she had never been informed that she needed to send a transfer notice and that she did not know what a transfer notice was. Facility staff were unable to provide documentation of a written transfer notice given to Resident #15 when he was transferred out of the facility on April 19, 2024, by the time of survey exit.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47955 This citation pertains to intake MI00144151 Based on interview and record review the facility failed to provide written notice of bed hold policy for 1 (Resident #15) of 1 resident reviewed for hospitalization resulting in the potential for the resident and/or the resident's representative to be unaware of the facility's bed hold policy, including duration, expense, and return process. Findings include: Resident #15 Review of an Admission Record revealed Resident #15 had pertinent diagnoses which included: Type two diabetes mellitus without complications, bipolar disorder, and insomnia. Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 3/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #15 was cognitively intact. Review of Health Status Note for Resident #15 dated 4/19/24 at 11:41 AM., revealed .referral has been placed to (Name Omitted) hospital and has been accepted for admission today. Secured transport for 1300 . Review of Health Status Note for Resident #15 dated 4/19/24 at 13:28 PM., revealed . Resident left facility via wheelchair .report called to (Name Omitted) general voicemail box and message left . In an interview on 5/22/24 at 12:49 PM., Resident #15 reported that neither he nor his daughter received a written bed hold policy before he transferred to (Name Omitted) hospital in mid-April. In an interview on 5/23/24 at 8:44 AM., Manager of Case Management (MCM) AAA reported that bed hold policies were sent with the resident when they transfer out of the facility. MCM AAA reported that the bed hold policies were scanned into the resident's medical record. When asked for Resident #15's bed hold policy from his transfer on 4/19/24, MCM AAA provided a bed hold policy that was undated and unsigned but did have Resident #15's name written on it. In an interview on 5/23/24 at 8:49 AM., Medical Records Assistant (MRA) F reported that the last bed hold policy scanned into Resident #15's medical record was scanned 2/7/24 and the bed hold policy was not dated and not signed. MRA F reported that he had written Resident #15's name on that bed hold policy when he transferred out of the facility in February. MRA F reported that Resident #15 did not sign a bed hold policy before he transferred out of the facility on 4/19/24. MRA F reported that Resident #15 did not have a bed hold policy in his electronic medical record from the transfer on April 19, 2024. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/23/24 at 9:40 AM., Director of Nursing (DON) B reported that bed hold policies signed by the resident or the resident's representative should be scanned into the resident's medical record. DON B reported that she assumed the nurse transferring the resident out of the building was to complete the bed hold policy. In an interview on 5/23/24 at 9:48 AM., RN XX reported that bed hold policies should be completed by the resident before they transferred out of the building. Facility staff were unable to provide documentation of a written bed hold policy given to Resident #15 when he was transferred out of the facility on April 19, 2024, by the time of survey exit. Review of facility policy Bed Hold Policy with an approved date of 5/8/24 revealed .At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed .

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on interview and record review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 2 (Residents #41 and #43) of 20 sampled residents reviewed for MDS accuracy, resulting in an inaccurate reflection of the residents' health status. Findings include: Resident #41 Review of an Admission Record revealed Resident #41 was a female, admitted to the facility on [DATE], with pertinent diagnoses which included: post-traumatic stress disorder, unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #41, with a reference date of 4/17/24 revealed, .Section I - Active Diagnoses in the last 7 days - Check all that apply . The check box next to Psychiatric/Mood Disorder .I6100. Post Traumatic Stress Disorder (PTSD) was not checked (indicating that the diagnosis did not apply to this resident). In an interview on 5/22/24 at 2:54 PM, MDS Coordinator (MDSC) LL reported she had completed Resident #41's MDS assessment dated [DATE], with input from other pertinent disciplines. MDSC LL reviewed said MDS with this writer and confirmed that PTSD had not been checked for Resident #41 but that it should have been checked because Resident #41 had a diagnosis of PTSD. MDSC LL reported the Active Diagnoses documented on the MDS assessment typically pulled over from the electronic medical record but for some reason the PTSD had not pulled over for Resident #41. MDSC LL reported the completed MDS documents were checked for accuracy before they were submitted to CMS (Centers for Medicare & Medicaid Services) but not every diagnosis/question was reviewed. MDSC LL reported she would have to correct Resident #41's MDS assessment and resubmit it because it was not accurate. Resident #43 Review of an Admission Record revealed Resident #43 was a male, with pertinent diagnoses which included: other lack of coordination. Review of a Minimum Data Set (MDS) assessment for Resident #43, with a reference date of 5/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #43 was cognitively intact. Further review of said MDS revealed, Section M - Skin Conditions .M0210. Unhealed Pressure Ulcers/Injuries Does this resident have one or more unhealed pressure ulcers/injuries? (There was a 1' in the box next to this question indicating Yes) .M0300B1. Number of Stage 2 pressure ulcers .Enter Number 1 (indicating Resident #43 had 1 Stage 2 pressure ulcer) . M0300B2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry Enter Number 0 (indicating that Resident #43 had acquired this pressure ulcer while at the facility). Review of a Skin/Wound Note dated 4/29/2024 at 15:24 (3:24 PM) revealed, Note Text: Resident has an open area to right ankle 0.5x0.5. NP (nurse practitioner) notified .Tx: (treatment) clean with NS (normal saline) apply Xeroform and band aid daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/21/24 at 12:21 PM, Resident #43 reported he did not have any pressure ulcers. In an interview on 5/22/24 at 11:27 AM, Assistant Director of Nursing (ADON) H reported the open area on Resident #43's right ankle was not a pressure ulcer. ADON H reported Resident #43 had a transport wheelchair and that he kept hitting his ankle on the wheel of the wheelchair which caused an injury to his right ankle. ADON H reported they had tried to give Resident #43 a different wheelchair, but that he had refused. ADON H reported she did not believe that Resident #43 had ever had a pressure ulcer. In an interview on 5/22/24 at 12:01 PM, MDSC Z reported she had completed Resident #43's MDS assessment dated [DATE]. This writer queried MDSC Z about the Stage 2 pressure ulcer that was coded under Section M - Skin Conditions of said MDS. MDSC Z reported she had thought the ankle wound was a pressure ulcer and coded it as such on Resident #43's MDS but realized yesterday that it was not a pressure ulcer, but rather was an injury caused by Resident #43 bumping his ankle on his wheelchair. MDSC Z reported she would have to modify Resident #43's MDS assessment and resubmit it because it was not accurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41424 Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 1 (Resident #6) of 20 residents reviewed for care planning resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual V1.17, Chapter 4, revealed, .the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Resident #6: Review of an Admission Record revealed Resident #6 was a male with pertinent diagnoses which included dementia, stroke, muscle weakness, dysphagia (damage to the brain responsible for production and comprehension of speech), pigmentary retinal dystrophy (rare, inherited disease causes the retina's light sensitive light cells to slowly break down leading to vision loss), repeated falls, anxiety, and monoplegia (complete or partial paralysis of a single limb). Review of current Care Plan for Resident #6, revised on 7/19/22, revealed the focus, .I am at High risk for falls r/t hx of falls, muscle weakness, pigmentary retinal dystrophy with legal blindness . with the intervention . Bed in low position, 9/1/23 .Make sure my glasses are within reach on my bedside tray, 7/3/23 .Hipsters to be worn over brief at all times .when I am in my broda chair I prefer to have the head of my chair all the way down almost touching the floor, 1/26/2024 . During an observation on 05/21/24 at 11:55 AM, Resident #6 was observed lying in bed, had blue wedges on the left side of his bed, bed was not low to the ground, his shirt had dried food on the chest area, rolled up towel behind his neck, knees bent upwards with his feet flat on the bed, his pillows were on the right side of the bed by the wall and not in use, and he was not positioned in the middle of the bed. During an observation on 05/22/24 at 07:58 AM, Resident # 6 was up out of his bed, seated in his broda chair at approximately 80 degrees. During an observation on 05/22/24 at 08:52 AM, Resident #6 was up in his broda chair in his room, staff had covered him with a blanket. He was saying he wants to lay down but no one was in the hallway to hear him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/23/24 at 08:41 AM, Resident #6 was lying in bed and his bed was not in a low position. There was no fall mattress next to his bed, no blue wedges on the side of the bed and it was folded and placed at the foot of the bed. His glasses were not in reach on the tray table, they were on the night stand out of his reach. The blue wedges were on the dresser at the foot of his bed. In an interview on 05/23/24 at 08:58 AM, Certified Nursing Assistant (CNA) Y reported Resident #6 was a fall risk and she had placed the call light by the side of the resident's legs. During an observation on 05/23/24 09:41 AM Resident #6 was observed in his room lying in his bed and his bed was not low, the fall mat was in place next to his bed, the blue wedges were not on the side of the bed, no hipsters in place and his glasses were located on the night stand out of his reach. In an interview on 05/23/24 at 09:23 AM, Quality Improvement Coordinator (QIC) D reported the CNAs would review the kardex for any interventions on how to take care of the resident, and would ensure the interventions were in place prior to leaving the room for the potential of falling for the resident. In an interview on 05/23/24 at 11:28 AM, Director of Nursing (DON) B reported she relied on the unit managers to ensure the care plan interventions were in place and the staff to anticipate the needs of the residents. DON B reported all of the management staff reviewed the care plan interventions, rounded and ensured those interventions were in place.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on interview and record review the facility failed to ensure residents received care in accordance with professional standards of nursing practice for 2 of 20 residents (Resident #6, #61) reviewed for physician orders and documentation, resulting in the potential for the worsening of a condition and a delay in treatment. Findings include: Review of the Fundamentals of Nursing revealed, Patient care requires effective communication among members of the health care team. The medical record is an important means of communication because it is a confidential, permanent, legal documentation of information relevant to a patient's health care. The record is a continuing account of a patient's health care status and is available to all members of the health care team. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 24088-24091). Elsevier Health Sciences. Kindle Edition. Resident #6: Review of an Admission Record revealed Resident #6 was a male with pertinent diagnoses which included dementia, stroke, muscle weakness, dysphagia (damage to the brain responsible for production and comprehension of speech), pigmentary retinal dystrophy (rare, inherited disease causes the retina's light sensitive light cells to slowly break down leading to vision loss), repeated falls, anxiety, and monoplegia (complete or partial paralysis of a single limb). Review of current Care Plan for Resident #6, revised on 11/21/23, revealed the focus, .The resident has recurrent Urinary Tract Infections and has prophylactic antibiotic in place . with the intervention .Encourage adequate fluid intake .Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness .Give antipyretics, analgesics and antispasmodics as ordered/PRN. Monitor/document for side effects and effectiveness .Monitor/document/report to MD PRN for worsening s/sx of UTI: Frequency, Urgency, Malaise, foul smelling urine, dysuria, Fever, nausea and vomiting, flank pain, Supra-pubic pain, Hematuria, Cloudy urine, Altered mental status, Loss of appetite, Behavioral changes . Review of Health Status Note dated on 3/29/2024 at 06:27 AM, revealed, .Catheter changed 14 fr; 5cc green, heavy sediment, pain with urination, and discolored. On coming staff and Md made aware of present assessment. Once placed there was a copious amount or (sic) return. Noted dry urine stains to bed sheets as if urine flowed around the indwelling cath . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician's Progress Note dated 4/1/2024 at 3:48 PM, revealed, .Associated Diagnoses: Hallucinations; Acute UTI (urinary tract infection); Urinary retention; Foley catheter present; Chronic kidney disease (CKD), stage III (moderate) .Seen in f/u with abnormal urinalysis .This is a [AGE] year-old male history of generalized weakness, schizophrenia, urinary retention with indwelling Foley catheter, hypertension, hyperlipidemia who is a long-term resident at skilled nursing facility .Hx of recurrent UTI infections - behavioral changes during this is hallucinations which prompted U/A .U/A show >180 wbc, + bacteria, + nitrates, + leuk esterase and 14 RBC Culture grew > 100K Proteus mirabilis and 10K -50K Kleb pneum .Resistant to Cipro in which he was previously started on and changing antibiotic therapy based on culture & Sensitivity .Results review: Lab results: 03/29/2024 06:00 EDT Source, UA U StraightCath .Color, UA Yellow Clarity, UA Cloudy Spec Gravity UA 1.015 pH Urine 9.0 HI Protein, UA 3+ .Hemoglobin, UA Trace Nitrite, UAPositive Leuk Esterase 3+ RBC, UA 14 /HPF HI WBC, UA >180 /HPF HI Bacteria, UAPresent . Documentation reviewed: Reviewed prior records .Case discussed with: nursing staff and resident . Impression and Plan: Diagnosis: Hallucinations, Acute UTI (urinary tract infection), Urinary retention, Foley catheter present, Chronic kidney disease (CKD), stage III (moderate) .Plan: Hallucinations secondary to urinary tract infection started on ceftriaxone which is susceptible to both organisms .Mix ceftriaxone with 2.1 mL of 1% lidocaine prior to administration .Encouraged and push fluids .Underlying urinary retention with Foley catheter and monitor urinary output .Does have underlying CKD stage III .Monitor vital signs and mentation for changes, if noted notify provider . Review of Infection Note dated 4/23/2024 at 2:02 PM, revealed, .Resident on Bactrim for UTI. Resident afebrile at 98.4 degrees. Catheter flushed with medicine as ordered. Continue plan of care . Review of Infection Note dated 4/29/2024 at 6:08 PM, revealed, .Resident on Bactrim for UTI; has foley catheter. Resident afebrile and foley flushed. No adverse reactions to Bactrim noted. Continue plan of care . Review of Physician's Progress Note dated 5/6/2024 at 3:11 PM, revealed, .DATE OF SERVICE: May 06, 2024 .SUBJECTIVE/INTERVAL: CC: Abnormal labs .This is a [AGE] year-old male history of urinary retention with indwelling Foley catheter, hypertension, hyperlipidemia who is a long-term resident at skilled nursing facility .C/O hallucinations - fearful and scary, intermittently throughout the day for the past few days . ASSESSMENT AND PLAN: 1. Hallucination .Check u/a with culture and sensitivity . Review of Health Status Note dated 05/6/2024 at 6:28 PM, revealed, .Urine specimen obtained and sent . Review of Urinalysis dated 5/6/24 revealed, .Source: U Clean Catch .Clarity, UA Cloudy .Nitrite, UA Positive . RBC UA, 9 .WBC, UA 52, Bacteria UA Present, Ca Oxal Cry, UA Present . Initialed by Nurse Practitioner (NP) DDD on 5/7/24 .Pending C&S . Review of Microbiology dated 5/7/24 at 2:56 PM, revealed, .Preliminary Report: Possible contamination . Initialed by Medical Director (MD) WW. Review of Microbiology dated 5/8/24 at 7:57 AM, revealed, .Final Report: Multiple bacterial species present; possible contamination; suggest appropriate recollection, with timely delivery to the laboratory, if clinically indicated . Initialed by NP DDD on 5/13/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/23/24 08:20 AM, Registered Nurse (RN) PP reported if she received notification of a contaminated urinalysis, she would contact the provider and obtain a new sample right away, and find out how they wanted her to proceed. RN PP reported she would normally remove the catheter, insert a straight cath to get a new sample from the resident and insert a new foley. RN PP reported if a urinalysis was needed for a resident, the foley was changed to obtain a sample. RN PP reported she would document this in the medical record. During an observation on 05/23/24 08:18 AM, Resident #6 was lying in his bed and there was thick, white milky urine with sediment in the urine as well as encrustations along the sides of the catheter tubing. In an interview on 05/23/24 at 09:14 AM, Quality Improvement Coordinator (QIC) D reported the urine sample should not had been taken from the catheter bag and the nurse would utilize the port to obtain the sample. The nurse would not change out the catheter unless an order was written by the provider to do so. QIC D reported when the urinalysis was received the nurse would speak to the provider to determine how they would like to proceed. This would be documented in the medical record by the nurse. QIC D reported no catheter would be changed out unless an order was received by the provider. QIC D reviewed the urinalysis report and determined the report was reviewed by Nurse Practitioner (NP) DDD. In an interview on 05/23/24 at 09:21 AM, QIC D reported to empty the catheter bag completely, wait 30 minutes and would have pulled the urine via the port on the catheter. QIC D reported the results would be reported to the physician and seek further direction. In an interview on 05/23/24 11:02 AM, Unit Manager (UM) SS reported the provider reported to her they decided not to treat or recollect a urinalysis as Resident #6 had no fevers, to suggest treatment further, and had spoken to the nurses and determined there was no reason to treat the resident. UM SS reported the conversation between the provider and the nurse should have been documented in the resident's medical record. QIC D reported when a result was reviewed by the provider they would initial the document. UM SS reviewed Resident #6's medical record and reported there was no documentation from the nurses on how the outcome of the conversation with the provider following the contaminated urine sample results on 5/8/24. In an interview on 05/23/24 10:45 AM, Unit Manager (UM) SS reported the nurses received the lab results prior to her. The nurses would contact the provider for hos to proceed. Reviewed Resident #6's medical record and reported there would be a notation and progress notes which indicated the UA was back, the NP (nurse practitioner) notified NP, obtained new orders at this time, notified the family results came back and the documented how the NP wanted to proceed. UM SS if it was determined to be urgent due to symptoms a broad spectrum antibiotic would be started until the culture and sensitivity (C&S) came back. However, the provider waited until the C&S came back to prescribe antibiotics. In an interview on 05/23/24 11:02 AM, Unit Manager (UM) SS reported the provider reported to her they decided not to treat or recollect a urinalysis as Resident #6 had no fevers, to suggest treatment further, and the provider had spoken to the nurses and determined there was no reason to treat the resident. UM SS reported the conversation between the provider and the nurse should have been documented in the resident's medical record. UM SS reviewed Resident #6's medical record and reported there was no documentation from the nurses on how the outcome of the conversation with the provider following the contaminated urine sample results on 5/8/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Urine Sample Collection revised on 1/15/24, revealed, .To promote accurate diagnosis and treatment of a resident's medical conditions, staff will obtain urine samples in accordance with established standards of practice .4. c. Indwelling Catheter specimen for urinalysis: i. Preferred: empty urine from tubing and catheter bag, disinfect the needleless sampling port and aspirate fresh urine with a sterile syringe/cannula adapter .6. Notify the physician of results, and file results in the resident's medical record . Resident #61: Review of an Admission Record revealed Resident #61 was a male with pertinent diagnoses which included stroke, dialysis, dementia, anxiety, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), aphasia (loss of the ability to understand or express speech caused by brain damage, like with a stroke), apraxia (neurological condition that makes it difficult or impossible to make certain movements), diabetes, and high blood pressure. Review of the Fundamentals of Nursing revealed, The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition. During an observation on 05/22/24 at 08:10 AM, Resident #61 was observed dipping his finger into a small medication cup with green gelatinous material in it and rubbed it on his shins of both legs and then proceeded to rub it on his forearms. Resident #61 reported the green gelatinous material was Biofreeze and he would also rub it on his neck, shoulder, and abdomen area as well as his legs and arms. In an interview on 05/22/24 at 01:03 PM, Registered Nurse (RN) G reported Resident #61 did have an order for Biofreeze because she reported she applied it on him. RN G conducted a review of Resident #61's record and it revealed no order for bio freeze. RN G reported Resident #61 would need to be assessed to self administer his medications and an order would be required for the Biofreeze and since it had been in a medicine cup staff must have provided it for him. Review of Order Summary for Resident #61 revealed, .Biofreeze External Gel 4 % (Menthol (Topical Analgesic)) .Apply to left thigh topically three times a day for pain .Discontinued: 1/30/2024 21:00 (9:00 PM) . Biofreeze External Gel 4 % (Menthol (Topical Analgesic)) .Apply to neck topically three times a day for pain . Discontinued: 1/27/2024 14:00 (2:00 PM) . During an observation on 05/22/24 at 01:24 PM, RN G was observed entering Resident #61's room and was searching his room. RN G exited the room without any items. In an interview on 05/23/24 at 09:25 AM, Quality Improvement Coordinator (QIC) D reported the facility conducted assessments to determine if a resident had the ability to self administer medications. QIC D reported the Biofreeze would require an order. QIC D reviewed the medical record and reported there was no order for the Biofreeze and no assessment for Resident #61 to self administer medications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41424 Based on interview and record review the facility failed to ensure that an agreement between themselves (the facility) and the dialysis provider (Name Omitted) was established and maintained, for 4 residents (Resident #61, #28, #20, & #75) of 4 reviewed for dialysis services resulting in the potential for disruption in the continuity of care and/or the interruption of dialysis treatments. Findings include: Resident #61: Review of an Admission Record revealed Resident #61 was a male with pertinent diagnoses which included stroke, dialysis, dementia, anxiety, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), aphasia (loss of the ability to understand or express speech caused by brain damage, like with a stroke), apraxia (neurological condition that makes it difficult or impossible to make certain movements), diabetes, and high blood pressure. Resident #28: Review of an Admission Record revealed Resident #28 was a female with pertinent diagnoses which included stroke, anemia, heart failure, high blood pressure, end stage renal disease, diabetes, paralysis, respiratory failure, acquired absence of left leg below the knee, and dependence on renal dialysis. Resident #20: Review of an Admission Record revealed Resident #20 was a male with pertinent diagnoses which included acute kidney failure with tubular necrosis, dependence on renal dialysis, heart failure, COPD, paralysis on right side following a stroke, anxiety, and dementia. Resident #75: Review of an Admission Record revealed Resident #75 was a female with pertinent diagnoses which included Heart failure, anemia, renal insufficiency, diabetes, anxiety, respiratory failure, encephalopathy (brain disease that alters brain function or structure), fluid overload, and dependence on renal dialysis. During an interview on 5/21/24 at 11:33 AM., during entrance conference with NHA A the agreement between the facility and the (Name Omitted) Dialysis provider was requested. During an interview on 5/22/24 at 01:50 PM, NHA A reported she had looked for the contract/agreement and was unable to locate it. NHA A reported she had reached out to the dialysis provider to obtain a copy from them. During an interview on 5/23/24 at 8:42 AM, NHA A reported the facility was unable to contact anyone at the dialysis provider but had not had any luck yet. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No contract or agreement between the facility and the (Name Omitted) Dialysis provider was provided prior to exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41982 Based on interview and record review, the facility failed to ensure the attending physician reviewed and responded to the registered pharmacist's monthly medication regimen review recommendations in a timely fashion for 1 (Resident #41) of 5 residents reviewed for medication regimen review, resulting in the registered pharmacist's recommendations not being addressed timely, and the potential for negative medication side effects or unnecessary medications as a result of the delayed response. Findings include: Review of an Admission Record revealed Resident #41 was a female, with pertinent diagnoses which included: saddle embolus of pulmonary artery without acute cor pulmonale (a blood clot in the lungs). Review of a progress note dated 5/6/24 at 9:16 PM revealed, Type: Medication Regimen Review Note Text: Monthly medication regimen review performed __x__ Comment/Recommendation noted - see report . electronically signed by contracted pharmacist (name omitted). On 05/22/24 at 3:30 PM, Resident #41's electronic medical record was reviewed for evidence of the pharmacist's report as mentioned in the 5/6/24 Medication Regiment Review progress note. No such document was found. This writer requested said report from Director of Nursing (DON) B at that time. DON B reported would have to get back to this writer. On 5/23/24 at 8:49 AM, 2 pharmacist Consultation Reports pertaining to Resident #41 were provided to this writer by DON B. Review of a pharmacist Consultation Report revealed, .Recommendation date: 05/06/2024 .Comment: (Resident #41) has a PRN (as needed) order for diphenhydramine. Anticholinergic antihistamines have strong, sedating anticholinergic properties and should be avoided in older adults. Recommendation: Please discontinue diphenhydramine and if appropriate, initiate PRN loratadine .Physician's Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: need for rash with itching - PRN . The response was signed and dated by Nurse Practitioner (NP) DDD on 5/23/24. Review of a pharmacist Consultation Report revealed, .Recommendation date: 05/06/2024 .Comment: (Resident #41) receives Eliquis (a blood thinner) and Aspirin Low Dose 81. Recommendations: Please discontinue the aspirin. Rationale for Recommendation: Concomitant use of apixaban (Eliquis) or edoxaban and select medications may further increase the risk for serious, potentially fatal bleeding. Combination therapy with an antiplatelet agent may be an appropriate choice in select higher risk individuals .Physician's Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: hx (history) of PE (pulmonary embolism) . The response was signed and dated by Nurse Practitioner (NP) DDD on 5/23/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/23/24 at 8:57 AM, with Nursing Home Administrator (NHA) A and DON B, DON B reported she had received the pharmacists Consultation Reports for Resident #41 on 5/8/24 via electronic mail. DON B reported once received, the Consultation Reports should be printed off and placed in the medical provider's mailbox for review. DON B reported once the medical provider reviewed the reports, they either accepted or declined the pharmacist's recommendations, signed and dated the report, and gave it back to DON B or designee to be scanned into the resident's electronic medical record. DON B reported the recommendations for Resident #41 should have been addressed sooner. NHA A reported there was a kink in the process that needed to be looked at.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on observation, interview, and record review the facility failed to: 1.) implement proper infection control protocols and practices that included Enhanced Barrier Precautions (EBP) per national standards of practice for 8 (Resident #43, #335, #65, #69, #6, #44, #5, #77) of 8 residents reviewed for infection control, and 2.) ensure that infection control policies were reviewed and/or updated on an annual basis. These deficient practices resulted in 1.) the increased potential for the spread of infection, bacterial harborage, cross contamination, and disease transmission for residents residing in the facility and 2.) the potential for facility infection control policies/procedures not being updated with current standards of practice for infection control. Findings include: Enhanced Barrier Precautions Review of Centers for Disease Control and Prevention (CDC) dated March 20,2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug resistant organisms) to staff hands and clothing .EBP are indicated for residents with any of the following: *Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or *Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Effective Date: April 1, 2024 . Resident #43 Review of an Admission Record revealed Resident #43 was a male, with pertinent diagnoses which included: benign prostatic hyperplasia (enlargement of the prostate gland, BPH) with lower urinary tract symptoms. Review of a Minimum Data Set (MDS) assessment for Resident #43, with a reference date of 5/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #43 was cognitively intact. Review of an active physician order for Resident #43 revealed, Maintain 16 French Foley catheter with 30ml (milliliters) [NAME] r/t (related to) Urinary Obstruction secondary to BPH. Change PRN (as needed) for obstruction. Every shift for Urinary Obstruction, BPH .Start Date 08/02/2023. In an observation/interview on 5/21/24 at 12:21 PM, Resident #43 was seated in his room in his recliner chair and agreed to speak with this writer. Resident #43 reported he had a catheter and that staff assisted him to maintain it. It was noted that there was no signage posted or personal protective equipment (PPE) for EBP despite resident having an indwelling medical device (the catheter). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/23/24 at 8:27 AM, Certified Nursing Assistant (CNA) JJ reported none of the residents were currently on EBP and no residents required additional PPE beyond standard precautions. In an interview on 5/23/24 at 12:02 PM, Infection Preventionist (IP) H reported the facility had not yet initiated the Enhanced Barrier Precautions Program. IP H reported the policy had been written and she was waiting for upper management to approve it. IP H reported once the policy was approved, she would conduct staff education. IP H estimated the program could be implemented within the next 2 months. Annual Review of Infection Control Policies Review of the facility policy Antibiotic Stewardship revealed a last reviewed/revision date of 5/21/19. Review of the facility policy Influenza Vaccination Policy revealed a last reviewed/revision date of 5/20/19. Review of the facility policy COVID-19 Vaccination revealed a last reviewed/revision date of 4/17/23. In an interview on 5/23/24 at 12:02 PM, Infection Preventionist (IP) H reported the infection control policies and procedures were currently being updated because they were outdated and had not been reviewed annually for a while. In an interview on 5/23/24 at 12:43 PM, Nursing Home Administrator (NHA) A reported the facility policies were in the process of being revamped and that the facility had started working on the infection control policies at the beginning of this month. NHA A reported every policy was supposed to be reviewed annually. This writer queried NHA A as to the reviewed/revision dates documented for the Antibiotic Stewardship, Influenza Vaccination, and COVID-19 Vaccination policies to which NHA A reported if the policy has a reviewed/revision date on it, that is the date they were last reviewed. 36221 Resident #335 Review of an Admission Record revealed Resident #335 was a male, with pertinent diagnoses which included osteomyelitis of vertebra (bone infection), bacteremia (bacteria in the blood), sepsis (an immune response triggered by an infection), and diabetes. Review of an Order Summary Report for Resident #335 revealed the active physician order .cefTRIAXone Sodium Injection Solution Reconstituted 2 GM (Ceftriaxone Sodium) Use 2 gram intravenously one time a day . with a start date of 5/20/24. No active physician order noted for Enhanced Barrier Precautions (EBP). Review of a current Care Plan for Resident #335 revealed the focus .I am on IV (intravenous) Medications for osteomyelitis . revised 5/20/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Summary note for Resident #335, dated 5/16/24 at 6:31 PM, revealed .Resident arrived with left PICC (peripherally inserted central catheter) line that is clean dry and intact . In an observation and interview on 5/22/24 at 9:27 AM, Registered Nurse (RN) X and Licensed Practical Nurse (LPN) I administered scheduled medications to Resident #335 in his room. Observed Resident #335 sitting in a chair in his room. Noted no signage on the door to indicate if additional Enhanced Barrier Precautions were required for care. No Personal Protective Equipment (PPE) noted near the entrance to Resident #335's room. RN X reported Resident #335 has a PICC line for administration of IV antibiotics. Observed RN X and LPN I administer Ceftriaxone Sodium Injection Solution 2 GM/100 mL . via PICC line for Resident #335. Noted RN X and LPN I wore gloves for administration of IV medication, however, no additional PPE was utilized. In an interview on 5/23/24 at 9:24 AM, Certified Nursing Assistant (CNA) EE reported no additional PPE is required when completing care for Resident #335. CNA EE reported if additional precautions were in place, there would be a sign on the door to indicate the type of precautions and PPE in a bin nearby. Resident #65 Review of an Admission Record revealed Resident #65 was a female, with pertinent diagnoses which included dementia, anxiety, high blood pressure, kidney disease, a history of falls, rhabdomyolysis (a breakdown of muscle tissue), and lymphedema (swelling caused by a lymphatic system blockage). Review of an Order Summary Report for Resident #65 revealed the active physician order .Cleanse Left buttock with Normal saline, apply Medi honey and cover with mepilex. every day shift for optimal wound healing . with a start date of 4/10/24. Review of an Order Summary Report for Resident #65 revealed the active physician order .cleanse right buttock with Normal Saline, apply Medi honey, cover with mepilex. every day shift for optimal healing . with a start date of 4/10/24. Review of an Order Summary Report for Resident #65 revealed the active physician order .Cleanse Right Medial Heel with Normal saline, apply Medi honey and cover with mepilex. every day and night shift for optimal healing . with a start date of 4/18/24. No active physician order noted for Enhanced Barrier Precautions (EBP). Review of a current Care Plan for Resident #65 revealed the focus .I have Left buttock pressure ulcer or potential for pressure ulcer development r/t (related to) Disease process . revised 4/18/24. Review of a current Care Plan for Resident #65 revealed the focus .I have Right Medial heel pressure ulcer or potential for pressure ulcer development r/t Disease process . revised 4/18/24. Review of a current Care Plan for Resident #65 revealed the focus .I have Right Buttock pressure ulcer or potential for pressure ulcer development r/t Disease process . revised 4/18/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 5/21/24 at 1:58 PM, Certified Nursing Assistant (CNA) DD provided toileting care for Resident #65 in her room. Noted CNA DD donned gloves to assist Resident #65 with toileting, however, no additional PPE was utilized. Noted no signage on the door to indicate if additional Enhanced Barrier Precautions were required for care. No Personal Protective Equipment (PPE) noted near the entrance to Resident #65's room. In an interview on 5/23/24 at 9:04 AM, Licensed Practical Nurse (LPN) J reported she completed Resident #65's wound care early in the morning. LPN J reported she utilized gloves for wound care, and reported no other PPE was required. 41424 Resident #69: Review of Admission Record revealed Resident #69 was a male with pertinent diagnoses which included orthopedic after care following surgical amputation, gangrene, diabetes, cognitive impairment, open wound right foot, sepsis, and dementia. Review of Skin/Wound Note dated 5/7/2024 at 6:22 PM, revealed, .Resident was seen on this day by UM (unit manager). Resident is being followed d/t left foot 1-5-digit amputation. Left foot is improved. Wound measured 1.0x0.6x0.2 wound dehiscence. POC reviewed and updated. Resident denied pain before, during and after assessment and tolerated assessment well. Resident had consented to being seen and is aware that he will be seen weekly until site heals; RP is aware. Current pain 0/10, Braden 16. Facility NP aware. Appropriate interventions are in place to aide in the healing process . Review of Order Summary dated 5/14/24, revealed, .Cleanse left foot with NS (normal saline) & pat dry. Pack with Iodoform gauze. Cover with dry gauze & secure with tape. Change on Monday & Thursday .every day shift every Mon, Thu for Amputation of left toes . Review of Order Summary for Resident #69 revealed no order for Enhanced Barrier Precautions. Review of Skin/Wound Note dated on 5/14/2024 1:27 PM, revealed, .Resident was seen on this day by UM. Resident is being followed d/t left foot 1-5-digit amputation. Left foot is improved. Wound measured 1.0cm x 0.6cm x0.2 wound dehiscence. Treatment orders changed per advanced vascular, Treatment: pack with iodoform cover with dry gauze change 2x a week. Resident denied pain before, during and after assessment and tolerated assessment well. Resident had consented to being seen and is aware that he will be seen weekly until site heals; RP is aware. Current pain 0/10, Braden 16. Facility NP aware. Appropriate interventions are in place to aide in the healing process. During an observation on 05/21/24 at 12:39 PM, Resident #69 was observed lying in his bed. No enhanced barrier precautions warning signs on the door or wall outside of the resident's room. No personal protective equipment (PPE) was observed outside of the resident's room or inside the room. During an observation on 05/21/24 at 12:56 PM, Registered Nurse (RN) RR entered Resident #69's room to bring his lunch tray. RN RR did not don PPE prior to entry. In an interview on 05/23/24 at 12:10 PM, Unit Manager (UM) SS reported vascular wanted him to still be on a treatment as he did have an open area still with some scabbing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6: Review of current Care Plan for Resident #6, revised on 10/24/23, revealed the focus, .I have an Indwelling Catheter d/t history of BPH (benign prostatic hyperplasia) . with the intervention .CATHETER: I have 14fr/10cc Catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door .Change foley catheter leg securement device every night shift every Sun for trauma prevention . Check tubing for kinks each shift . Review of current Care Plan for Resident #6, revised on 10/24/23, revealed the focus, .I have an Indwelling Catheter d/t history of BPH . with the intervention .CATHETER: I have 14fr/10cc Catheter). Position catheter bag and tubing below the level of the bladder and away from entrance room door .Change foley catheter leg securement device every night shift every Sun for trauma prevention D .Check tubing for kinks each shift . During an observation on 05/21/24 11:47 AM, Resident #6 was lying in his bed. There was no warning sign for enhanced barrier precautions on the wall or the door to the room. No PPE was available outside the room or inside. During an observation on 05/21/24 at 12:55 PM, Resident #6 was lying in his bed and staff delivered his lunch, offered him a clothing protector, and placed his lunch on the rolling beside table. Observed at 05/21/24 at 01:00 PM, Resident #6's lunch tray was sitting on the rolling table. At 01:11 PM, Certified Nursing Assistant (CNA) L entered the room to provide assistance with Resident #6's lunch. Resident #44: Review of Admission Record revealed Resident #44 was a male with pertinent diagnoses which included malignant neoplasm of prostate (prostate cancer), acute kidney failure, hydroureter (ureter - tube that carries urine from the kidneys, becomes abnormally enlarged due to blockage), and high concentration of sodium in the blood. Review of current Care Plan for Resident #44 revealed the focus, .I have an Indwelling Catheter (foley: 16Fr/10cc) d/t malignant neoplasm of prostate, urinary retention, hydroureter, obstructive and reflux uropathy with the intervention . The resident will be/remain free from catheter-related trauma through review date . Check tubing for kinks each shift .Dignity bag .Monitor for s/sx of discomfort on urination and frequency . Monitor/document for pain/discomfort due to catheter .Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns .Position catheter bag and tubing below the level of the bladder and away from entrance room door . Review of Medicare Note dated 5/20/2024 at 12:04 PM, revealed, .NP (Nurse Practitioner DDD) notified, new order UA C&S d/t dark urine, odor, and sediment report results to NP when available . Review of Health Status Note dated 5/22/2024 at 12:10 PM, revealed, .Resident refuses to let nurse change his catheter and collect UA . Review of Orders for Resident #44 revealed no orders for Enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/23/24 at 08:20 AM, Registered Nurse (RN) RR reported Resident #44 needed to have a urinalysis conducted and he had refused to allow for the nurse to change out his foley to obtain the sample. During an observation on 05/21/24 at 12:33 PM, no enhanced barrier precautions warning signs were observed on the door to the resident's room and no personal protective equipment (PPE) was noted outside the room or inside the room. During an observation on 05/21/24 at 12:59 PM, Resident #44 was brought lunch by Certified Nursing Assistant (CNA) AA. CNA AA did not don PPE prior to entering the room. 48637 Resident #5 (R5) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R5's original admitted to the facility was on 3/22/2024 with a diagnosis of neurogenic bladder. Brief Interview for Mental Status (BIMS) score was a 15 which indicated that she was cognitively intact (13-15 cognitively intact). She was admitted to Hospice care on 5/7/2024. During initial screening on 5/21/2024 at 1:06 PM, it was observed that R5 had an indwelling medical device (catheter) and didn't have an enhanced barrier precaution sign posted outside her door or personal protective equipment (PPE). Review of R5's chart revealed the following physician order Monitor foley catheter 16 fr (French size) /10cc (volume) balloon r/t (related to) neurogenic bladder. Change PRN (as needed) for obstruction every shift for infection control/hygiene AND as needed for infection control, hygiene. During an interview on 5/23/2024 at 11:15 AM, R5 stated that staff wears gloves while providing care but they don't wear a gown or mask. During an interview on 5/23/2024 at 10:42 AM, Hospice Aide (HA) V stated that he was aware R5 had a catheter but he didn't use additional PPE beyond standard precautions while taking care of her. Resident #77 (R77) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R77 was admitted to the facility on [DATE] with a diagnosis of retention of urine. Brief Interview for Mental Status (BIMS) score was a 12 which indicated her cognition was moderately impaired (8-12 moderately impaired). During initial screening on 5/21/2024 in the afternoon, it was observed that R77 had an indwelling medical device (catheter) and didn't have an enhanced barrier precaution sign posted outside her door or personal protective equipment (PPE). Review of R77's chart revealed the following physician order Monitor foley catheter 16 fr (French size) /10cc (volume) balloon r/t (related to) neurogenic bladder. Change PRN (as needed) for obstruction every shift for infection control/hygiene AND as needed for infection control, hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/2024 at 7:50 AM, Certified Nursing Assistant (CNA) CCC was observed going into R77's room without putting PPE on to get her ready for a shower. During an interview on 5/23/2024 at 10:30 AM, R77 stated that staff wears gloves while providing care but they don't wear a gown or mask. During an interview on 5/23/2204 at 10:40 AM, Licensed Practical Nurse (LPN) E stated that there weren't any residents on her hall that staff needed to wear additional PPE with beyond standard precautions. During an interview on 5/23/2024 at 11:13 AM, CNA CCC stated that there weren't any residents she had to wear additional PPE beyond standard precautions while providing care. CNA CCC said that she only wears gloves when emptying a catheter.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation and interview the facility failed to ensure a sanitary environment for 1 of 1 (Resident #6) and personal and shared medical equipment reviewed for sanitary conditions, resulting in the potential for cross-contamination, infections, and bacterial harborage. Findings include: During an observation on 05/22/24 at 08:35 AM, outside of room [ROOM NUMBER] there was a broda chair left arm rest area inside had dried liquid/soiled, the back had a black pad and it was soiled with dirt and needed to be cleaned and wiped down, the foot rest had dirt/debris on it, the black thick cushion on the seat had white specks on it, the black pad on the left side lower area had a white dried smear and on the bottom middle area. Dirt and debris was in the crevice between the two blue pads. The left inside of the side guard armrest area had white material smeared on it. The blue pad behind the black pad on the seat on had splatters of dried brown/tan/white specks over the top of it. During an observation on 05/23/24 at 08:29 AM, the broda chair had MID1808114 on the handle on the back of the chair and it was located between room [ROOM NUMBER] and 25. The back rest had white streaks down at the bottom of the pad, where the blue back pad and black seat pad meet there was smeared dirt/material. The armrest on the left side had dirt/debris in the seams that connected to the blue padding on the side to the seat. Under the black seat pad was food crumbs, dirt and debris. The hoyer lined up along the wall behind it had purple wipes in a plastic bag. The recliner seat by room [ROOM NUMBER] had a noted number of 55182550161 on the spindle of the back the chair. The black seat pad had dried white and brown material on it, scattered across it. The arm rest had a box under it with the suppliers name on it and between the arm rest and that box was dirt and debris which had lined it. Resident #6: Review of an Admission Record revealed Resident #6 was a male with pertinent diagnoses which included dementia, stroke, muscle weakness, dysphagia (damage to the brain responsible for production and comprehension of speech), pigmentary retinal dystrophy (rare, inherited disease causes the retina's light sensitive light cells to slowly break down leading to vision loss), repeated falls, anxiety, and monoplegia (complete or partial paralysis of a single limb). During an observation on 05/22/24 at 07:58 AM, Resident # 6 was up and in his broda chair, approximately 80 degrees. His catheter was hanging from the front left side under the chair, the right side of the broda chair, the space from front to back had dried white splattered material on it, the wall side of his bed had brown liquid splatters which were dried, there were black/grey streaks down the wall. The fall mat needed to be cleaned. There were the light blue wedges in the room on the dresser which needed cleaning, there were various locations of spots on the wedges, the corners were soiled, there was a spot where tape had been and the adhesive was still there all splotchy with dirt/debris. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/23/24 at 08:59 AM, Certified Nursing Assistant (CNA) Y reported she normally was assigned to work the night shift. CNA Y reported on the night shift the staff would clean the resident's wheelchairs. There was a schedule when each room was completed. In an interview on 05/23/24 at 01:52 PM, CNA JJ reported the fall mats were usually cleaned by housekeeping but if there was something spilled on it she would clean it up. In an interview on 05/23/24 at 01:58 PM, Licensed Practical Nurse (LPN) E reported the wheelchairs and broda chairs were cleaned on third shift and there was a schedule for staff to follow. LPN E reported it was everyone's responsibility to ensure the fall mats were cleaned. Review of Cleaning and Disinfection of Resident Care Equipment approved on 05/08/2024, revealed, .Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection .2. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include: Verify whether the equipment is single-use or reusable. Discard single-use items after use .Each user is responsible for routine cleaning and disinfection of multi-resident items .Direct care staff are responsible for cleaning single-resident equipment when visibly soiled, and according to routine schedule (where applicable) .Most equipment may be cleaned/disinfected in the areas in which the equipment is used . 41982 During an observation on 5/21/24 at 12:09 PM, noted a broda chair (a high-back positioning chair) located in the hallway outside of room [ROOM NUMBER]. There was a significant amount of dirt and grime around the wheels and wheel casters. There was unidentified dried spillage on the seat and both arm rests. Also noted was a hoyer lift machine (a device used to lift and transfer a person from one surface to another) outside of room [ROOM NUMBER] that had dried red spillage on the bottom frame of the machine. During an observation on 5/22/24 at 08:34 AM, noted a broda chair (a high-back positioning chair) located in the hallway outside of room [ROOM NUMBER]. There was a significant amount of dirt and grime around the wheels and wheel casters. There was unidentified dried spillage on the seat and both arm rests. Also noted was a hoyer lift machine (a device used to lift and transfer a person from one surface to another) outside of room [ROOM NUMBER] that had dried red spillage on the bottom frame of the machine. In an interview on 5/23/24 at 12:02 PM, Infection Preventionist (IP) H reported resident shared equipment should be cleaned before and after each use.