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	03/12/2025

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to respond timely to call lights to maintain resident dignity for 5 (Residents #4,#10, #22, #36 and #237) of 7 residents reviewed for dignity, resulting in episodes of incontinence and feelings of frustration and loss of self-worth with the potential for overall deterioration of psychological well-being. Findings include: Resident #4 Review of an Admission Record revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 1 diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 2/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #4 was moderately cognitively impaired. During an interview on 3/10/25 at 2:32 PM Resident #4 reported that he was frustrated with the long call light wait times. Resident #4 reported that he had recently had to wait almost an hour for staff assistance after he had a bowel movement and needed help getting cleaned up. Resident #10 Review of an Admission Record revealed Resident # 10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included overactive bladder. Review of a Minimum Data Set (MDS) assessment for Resident #10, with a reference date of 12/30/24 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #10 was moderately cognitively impaired. During an interview on 3/10/25 at 2:46 PM, Resident #10 reported concerns with long call light wait times. Resident #10 reported that she frequently had to wait for up to an hour for staff assistance, and it made her feel like staff did not care about her. Resident #22 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #22 was originally admitted to the facility on [DATE] with pertinent diagnoses which included history of falling. Review of a Minimum Data Set (MDS) assessment for Resident #22, with a reference date of 12/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #22 was cognitively intact. During an interview on 3/10/25 at 12:47 PM, Resident #22 reported that the facility often had long call light wait times, which was frustrating. During an interview on 3/12/25 at 11:08 AM, Unit Manager (UM) FF reported that she was aware that many residents had concerns with long call light wait times in the past, but she thought that the situation had improved since the facility had completed education with staff. UM FF reported that she reviewed call light reports weekly to ensure that residents were not waiting for extended periods of time. UM FF reported that it was her expectation that a call light be answered within 15 to 20 minutes at the latest. This writer requested any maintenance orders for Resident #4, Resident #10 and Resident #22's call lights in the past 30 days and education that was provided to staff on call light response time in the past 3 months. During an interview on 3/12/25 at 1:35 PM, Nursing Home Administrator (NHA) A reported that the facility staff had not had recent education on call light response time. The facility was unable to provide any work orders to show potential call light errors for Resident #4, Resident #10 and Resident #22 prior to survey exit. 36221 Resident #36 Review of an Admission Record revealed Resident #36 was a male, with pertinent diagnoses which included dementia, anxiety, diabetes, depression, and a history of falls. Review of a Minimum Data Set (MDS) assessment for Resident #36, with a reference date of 12/24/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated moderate cognitive impairment. In an observation and interview on 3/10/25 at 4:08 PM, Resident #36 was noted in bed in his room, covered with a blanket. Resident #36 stated .Is my call light working? Observed the call light screen at the nurses' desk, which indicated Resident #36 had activated his call light at 3:33 PM. Noted two staff members sitting at the nurses' desk working on paperwork. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 3/10/25 at 4:10 PM, Resident #36 was noted in bed in his room, covered with a blanket. Noted Resident #36's call light remained activated. Resident #36 reported he had been waiting for staff to respond to his activated call light for an extended period of time. Resident #36 reported he was hungry and would like something to eat. After a few minutes, Resident #36 got up independently from his bed, walked out of his room, and left the unit to try and find a staff member for assistance. In an observation on 3/10/25 at 4:18 PM, Certified Nursing Assistant (CNA) GG responded to Resident #36's activated call light. At this time, Resident #36 was no longer in the room. Observed CNA GG turn off Resident #36's call light and exit the room. Noted Resident #36's call light was activated for a total of 45 minutes. 38384 R237 According to R237's medical record, the resident's BIMS (Brief Interview Mental Status) dated 3/4/24, score was 13/15 (cognitively intact). Review of R237's Order Summary, dated 2/28/25, indicated the resident had a urinary catheter related to urinary retention. During an observation and interview on 03/10/25 at 11:13 AM, R237 and Family Member (FM) PP were in the resident's room with the call light turned on at bedside. FM PP stated, I have had the call light on since 11:00 AM. I am here quite a bit because staff does not get (R237) dressed and up out of bed early like he likes to be. Today, I got here at 10:30 AM and staff have not gotten him up yet. Observed resident in bed wearing a gown. On his forehead was a blood-soaked bandage. The pillow and sheet under the resident's head had wet blood on it. Observed on 3/10/25 at 11:37 AM the call light still not answered. FM PP stated, I want those bandages to be changed because they are leaking all over his gown. Observed on 3/10/25 at 11:43 AM the call light still not answered. FM PP stated she was told by a nurse when the resident was first admitted (2/28/25), call lights do not come on over door that they are digital on a screen at the nursing desk. At this time the surveyor walked out of the room and looked up at the call light above the door. Registered Nurse (RN) M saw the surveyor look at the call light but did not come to assist resident. The wound on R237's head continued to bleed through the bandage onto the pillow and sheet. Observed on 3/10/25 11:49 AM, Certified Nursing Assistant (CNA) HH entered R237's room. FM PP told CNA HH R237 was bleeding and needed to get dressed and out of bed. The CNA stated she would tell the nurse and brought in clean linens and towels, left them on a chair and walked out. Observed on 3/10/25 at 11:54 AM, FM PP leaving R237's room to find staff because the resident had to use the bathroom. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observed on 3/10/25 at 12:12 PM, RN M came into R237's room with CNA HH and the resident telling them he needed to have a bowel movement and did not want to have an accident. CNA HH stated she would assist him to the bathroom when she found another CNA to assist her. It was noted the two CNAs came back to assist R237 within five minutes. Review of facility policy, Call Lights dated 3/7/2024, revealed, .Call lights will directly relay to a staff member or centralized location to ensure appropriate response .Staff will ensure the call light is within reach of resident and secured, as needed .All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure confidential resident health information was protected and private for 1 of 1 (Residents #71) residents reviewed for privacy and federally regulated HIPAA (Healthcare Insurance Portability and Accountability Act). Findings include Review of an Admission Record revealed Resident # 71 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes. During an observation on 3/12/25 at 10:30 AM, Licensed Practical Nurse (LPN) K was preparing medications at her medication cart. After preparing medications, LPN K walked away from her cart and entered a resident's room. It was noted that the computer screen was left open, with multiple resident names noted on the screen in view of anyone that walked down the hallway and past the medication cart. LPN K was noted to be away from the cart for 6 minutes. During an observation on 3/12/25 at 10:42 AM, LPN K was preparing medications at her medication cart. After preparing medications, LPN K walked away from her cart and entered a resident's room. It was noted that the computer screen was left open, with multiple resident names noted on the screen in view of anyone that walked down the hallway and past the medication cart. LPN K was noted to be away from the cart for 5 minutes. During an observation on 3/12/25 at 10:50 AM, LPN K was preparing medications at her medication cart. After preparing medications, LPN K walked away from her cart and entered a resident's room. It was noted that the computer screen was left open, with multiple resident names noted on the screen in view of anyone that walked down the hallway and past the medication cart. LPN K was noted to be away from the cart for 5 minutes. During an observation on 3/12/25 at 12:37 PM, LPN K was preparing medications at her medication cart. After preparing medications, LPN K walked away from her cart and entered a resident's room. It was noted that the computer screen was left open with Resident #71's medical information noted on the screen and in view of anyone that walked down the hallway and past the medication cart. LPN K was noted to be away from the cart for 10 minutes. It was noted that several staff members walked past the open screen when Resident #71's medical information was open to view. During an interview on 3/12/25 at 12:47 PM, LPN K reported that she knew that she was supposed to lock her computer screen when she was not at her cart to keep resident medical information secure, but she just forgets sometimes.

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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. 38384 Based on observation, interview and record review the facility failed to ensure adequate assessment for 1 (R237) of 1 resident reviewed for quality of care when, resulting in R237 receiving a delay in treatment for abrasions. Findings include: According to R237's medical record, the resident's BIMS (Brief Interview Mental Status) dated 3/4/24, score was 13/15 (cognitively intact). R237's diagnoses included fracture of left femur (thigh bone) start date 1/2/25, history of falling start date 10/22/16. Review of R237's Incident Fall Report dated 3/9/25 at 11:50 AM indicated the resident was noted on the floor face forward and had stated he had slid off wheelchair. The resident was assessed for injuries and pain then assisted back to his wheelchair. Injuries included a skin tear 2.5 cm x 2.5 cm to forehead, and both the right and left knee along with bruises to right side of face, neck, and chest. Review of R237's Order summary dated 3/10/25, revealed, Monitor steri strips (thin adhesive bandages to close wound) to right knee skin tear for placement - allow to naturally remove. every morning and at bedtime for wound care. Review of R237's Medication/Treatment Administration Record (MAR/TAR) dated 3/10/25 at 7:00 PM, revealed, Monitor steri strips to right knee skin tear for placement - allow to naturally remove. every morning and at bedtime for wound care -Start Date 03/10/2025 1900 (7:00 PM). During an observation and interview on 3/10/25 at 11:13 AM, Family Member (FM) PP and R237 were in the resident's room. The resident had a head and bilateral (both) knee wounds covered with blood saturated dressings. The knee dressings were not dated. R237 stated, I fell asleep in my wheelchair and fell out and hit my head and knees. Observed the resident's pillow and sheets were stained with blood. During an observation on 3/10/25 at 11:55 AM Registered Nurse (RN) M entered R237's room to assess the resident's head wound that was bleeding through the bandage. The RN stated she had changed the bandage on R237's head earlier that morning but not his knees. It was observed R237's right knee was bleeding through the bandage and staining the sheet and blanket with blood. RN M left the room stating she was going to talk with the nurse practitioner (NP). During an observation on 3/10/25 at 12:12 PM, RN M entered R237's room and spoke with the resident and FM PP stating she had new orders from the NP for R237's head wound but did not talk to the NP about the wounds on R237's knees because they were not charted on his post-fall documentation. During an interview on 3/12/25 at 10:16 AM, Director of Nursing (DON) B stated, My expectations of staff with a resident fall is to do a head-to-toe fall assessment. The staff would follow the fall policy and document findings in the resident's progress note. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/25 at 1:22 PM, Unit Manager (UM) BB stated, My expectations of nurses doing a fall assessment is they would do a skin assessment to find out if there were any injuries. (RN P) told me (R237's) knees were not bleeding when she pulled up his pant legs doing the fall assessment she did. (RN VV) was also there after (R237) fell and told me she did a full skin assessment put it in (R237's) medical chart. I have full faith in the thoroughness in both nurse's assessments. During an interview on 3/12/25 at 2:44 PM, CNA GG stated, I found (R237) on the floor. He was next to the bed in between the wheelchair and nightstand. He had scrapes on his knees and grazed his head. I saw later when another staff and I put back in the bed for the night and put him in the gown that he had a scrape on his right knee and his head was bleeding.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure a resident received proper treatment to maintain vision abilities for 1 of 1 resident (Resident #4), reviewed for vision services, resulting in the inability of the resident to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. Findings include: Resident #4 Review of an Admission Record revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 1 diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 2/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #4 was moderately cognitively impaired. Review of Resident #4's Care Plan revealed, I (Resident #4) have impaired visual function. Start date: 11/18/24. Interventions: Arrange consultation with eye care practitioner as required. Date initiated: 11/18/24 . Review of Resident #4's Orders dated 12/30/24 and documented by Medical Director (MD) JJ revealed, Consult the visiting optometrist. (Resident #4) has low vision. The magnifier on his left glasses lens is clouded; reducing vision further. See if optometrist can check and prescribe for new glasses. It was noted that this order did not have a completion date. Review of Resident #4's Progress notes dated 2/2/25 and documented by Licensed Practical Nurse (LPN) U revealed, The resident brought his bifocal that is attached to his eye glass to this writer, it was placed in the nurses cart in two medication cups, taped together, labeled with his name. During an observation and interview on 3/10/25 at 2:32 PM, Resident #4 was sitting in his room. Resident #4 reported that the bifocal (type of lens) on his glasses had been broken for months and the facility had told him they would fix it, but he had not heard anything about why he had not seen an eye doctor yet. Resident #4 reported he needed his glasses to see, and it was becoming harder for him to complete daily tasks with broken glasses. It was noted that Resident #4's glasses appeared to have only one bifocal lens, which was cloudy. During an interview on 3/12/25 at 10:12 AM, Medical Records Assistant (MRA) II reported that she was the staff member responsible for scheduling appointments for residents. MRA II reported that she had not received any orders for Resident #4 to see an optometrist, so she had not scheduled Resident #4 for an appointment. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/25 at 11:02 AM, Unit Manager (UM) FF reported that she was unaware that Resident #4 had broken glasses and needed to see an optometrist. UM FF reviewed Resident #4's orders with this writer and reported that the order that was placed by MD JJ for Resident #4 to see an optometrist was placed incorrectly, and therefore it was missed. When this writer queried about the note on 2/28/25 documented by LPN U, UM FF reported that she was not made aware of that incident. UM FF reported that she typically reviews progress notes daily, but she must have missed that note. UM FF confirmed that Resident #4 never saw an eye doctor, and did not have an appointment scheduled. During an interview on 3/12/25 at 11:26 AM, MD JJ reported that he had placed an order for Resident #4 to see an optometrist because he had broken glasses, and was overdue for a diabetic eye exam. MD JJ reported that he was unaware that Resident #4 had not yet been scheduled for an vision appointment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview and record review, the facility failed to provide coordination of care and services for a Foley catheter (flexible tube inserted through the urethra and into the bladder to drain urine) according to professional standards of practice for urinary catheters for 1 of 2 residents (Resident #42) reviewed for catheter care, resulting in Resident #42 continuing to experience urinary tract infections (UTI) with the potential for complications related to urinary tract infections. Findings include: Resident #42 Review of an Admission Record revealed Resident #42 was originally admitted to the facility on [DATE] with pertinent diagnoses which included obstructive and reflux uropathy (a condition where urine flow is blocked and can back up in the kidneys). Review of Resident #42's Care Plan revealed, I have an indwelling catheter: Neurogenic bladder (a condition that occurs when the nervous system connection to the bladder is disrupted, causing bladder control issues). Date initiated: 10/4/24. Interventions: Monitor for s/s (signs and symptoms) of discomfort on urination and frequency. Date initiated: 10/4/24 . Review of Resident #42's Orders revealed, Change the foley catheter after 48 hours due to UTI (urinary tract infection). Antibiotics starting today x 14 days. Start date 1/8/25. It was noted that this order did not have a completion date. Review of Resident #42's Physician Progress Notes dated 1/8/25 and documented by Medical Director (MD) JJ revealed, .Chief complaint: I am seeing the patient (Resident #42) today because of a urinary tract infection. He had a recent UA (urinalysis) which was abnormal and positive culture for UTI. He has been started on ciprofloxacin (antibiotic) . Physical Exam: .He has an indwelling Foley catheter. There is a lot of sediment (buildup of crystals, minerals, and salts from urine that can cause blockages within the catheter and drainage system) in the tubing .ASSESSMENT/PLAN: 1. Urinary tract infection with Pseudomonas aeruginosa and Enterococcus species (type of bacteria). Also heavy yeast . After 48 hours the Foley catheter will be changed. At that point the antibiotic levels will be established and will remove the whole catheter so it does not reinfect the bladder Review of Resident #42's Physician Progress Notes dated 2/13/25 and documented by Nurse Practitioner (NP) WW revealed, .Subjective: Seen in follow-up for abnormal urinalysis .Plan: Acute cystitis; treat with nitrofurantoin twice daily x 5 days, push fluids and encouraged him to drink cranberry juice. Staff to exchange Foley . During an observation on 3/10/25 at 2:16 PM, Resident #42 was lying in his bed. Resident #42's catheter was attached to his bed and the bottom of the catheter bag was sitting on the floor. Heavy sediment was noted in Resident #42's catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 12:06 PM, Unit Manager (UM) FF reported that she was unaware that Resident #42 had an order placed in 1/2025 for his catheter to be changed. UM FF reviewed the order dated 1/8/25 and confirmed that the order had not been completed. UM FF reviewed Resident #42's medical record and reported that she could not find any documentation that Resident #42's catheter had been changed. UM FF reported that she would reach out to Resident #42's hospice nurse to see if he had changed Resident #42's catheter. During an interview on 3/11/25 at 12:45 PM, Assistant Director of Nursing (ADON) G reported that she had discovered that MD JJ was entering orders incorrectly, and so the facility had not been aware that MD JJ had ordered for Resident #42's catheter to be changed on 1/8/25. ADON G' confirmed that Resident #42 had had an additional UTI in February 2025. During an interview on 3/11/25 at 3:21 PM, Hospice Nurse (HN) RR reported that he had not changed Resident #42's catheter. HN RR confirmed that he was unaware that MD JJ had placed an order to have Resident #42's catheter changed. During an interview on 3/12/25 at 11:26 AM, MD JJ reported that he had placed an order on 1/8/25 for Resident #42's catheter to be changed. MD JJ reported that he was aware that the facility had not changed the catheter.

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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. 36221 Based on interview, and record review, the facility failed to ensure the physician reviewed and responded to the licensed pharmacist's monthly medication regimen review recommendations in a timely manner in 1 of 5 residents (Resident #14) reviewed for unnecessary medications, resulting in the potential for medication interactions and adverse side effects. Findings include: Resident #14 Review of an Admission Record revealed Resident #14 was a male, with pertinent diagnoses which included diabetes, insomnia, anxiety, and depression. Review of a pharmacy Consultation Report for Resident #14, dated 1/10/25, revealed .(Resident #14) frequently requires insulin per sliding scale (despite) a routine basal-bolus insulin regimen. The patient is averaging 105 units of insulin daily between the basal-bolus insulin regimen and sliding scale . Recommendation: Please discontinue the sliding scale, change insulin glargine to 54 units daily (50% of total daily insulin), change insulin Lispro to 17 units TID (three times per day) (50% of total daily insulin / 3 meals) and draw QID (four times per day) blood glucose readings until dosage adjustments have been made and regimen has stabilized. Dosage adjustments will most likely be needed and can be done in as little as every 3 days . Noted the Physician responded to the recommendation on 3/12/25, more than two months later. Review of a pharmacy Consultation Report for Resident #14, dated 1/10/25, revealed .(Resident #14) receives a leukotriene receptor antagonist, Montelukast Sodium, and has a diagnosis of insomnia, requiring treatment with zolpidem at a higher dose than what is recommended by the manufacturer. The FDA (U.S. Food and Drug Administration) issued a black box warning (a label required for medications with serious safety risks) for montelukast due to increased neuropsychiatric side effects, including insomnia . Recommendation: Please discontinue the montelukast . Noted the Physician responded to the recommendation on 3/12/25, more than two months later. Review of a pharmacy Consultation Report for Resident #14, dated 2/6/25, revealed .(Resident #14) has two routine orders and one additional PRN (as needed) order for Miralax, exceeding the maximum daily dosage of 34 grams .Recommendation: Please reevaluate the need for both agents, perhaps giving consideration to discontinuing use of the PRN and one additional routine order . Noted the Physician responded to the recommendation on 3/12/25, over a month later. Review of a pharmacy Consultation Report for Resident #14, dated 2/6/25, revealed .(Resident #14) receives a tricyclic antidepressant, Doxepin Hydrochloride .6 mg Give 1 tablet by mouth one time a day for anxiety, which should be avoided in older adults due to the risk of syncope, orthostatic hypotension, and strong, sedating anticholinergic properties .Recommendation: Please reduce Doxepin Hydrochloride to 3 mg QD (once daily) with the end goal of discontinuation . Noted the Physician responded to the recommendation on 3/12/25, over a month later. (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 3/12/25 at 12:52 PM, Director of Nursing (DON) B reported pharmacy Consultation Reports should be given to the physician to either agree or disagree with the recommendations made. DON B reported physician orders should be placed as necessary based on the recommendations. Review of the policy/procedure Medication Regimen Review, dated 4/24/24, revealed .The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart .Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes . Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities .The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed .The pharmacist shall communicate any irregularities to the facility in the following ways .Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing .Timelines and responsibilities for Medication Regimen Review .The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review .Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities .

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38666 Based on observation, interview, and record review the facility failed to provide adaptive dining equipment for 2 (Residents #3 and #4) of 2 residents reviewed for adaptive dining equipment resulting in spills, frustration, decreased independence with eating and drinking, and the potential for weight loss or dehydration.Findings include: Resident #3 During an observation and interview on 03/10/25 at 12:56 PM, Resident #3 was lying in bed with her bedside table over her. The bedside table had a disposable foam cup (no handles) with lid and straw that contained what appeared to be water. There was also a dual handled cup with spout lid containing another beverage. Resident #3 reported she used the dual handled cup because she is blind and it helps her drink and avoid spilling on herself which she reported she had done previously with other cups. Resident #3 confirmed the dual handled cup helps her drink independently. During an observation and interview on 03/11/25 at 12:46 PM, Certified Nurse Aide (CNA) EE was observed putting on personal protective equipment to be able to enter and take Resident #3's lunch to her. Resident #3's meal ticket indicated to provide a dual handled cup and a scoop plate, but neither adaptive dining device was provided with the meal. The beverage on Resident #3's tray was a can of cola. CNA EE confirmed Resident #3 had a dual handled cup in her room already but it contained water so there wasn't a dual handled cup to put the soda in. CNA EE also confirmed the lunch was served in a disposable divided foam container and there was no scoop plate. The food's container wasn't a scoop plate and couldn't serve the same function as a scoop plate. During an interview on 03/11/25 at 04:05 PM, Licensed Practical Nurse CC reported the reason Resident #3 didn't receive the adaptive dining equipment, dual handled cup and scoop plate, was because Resident #3 was on droplet precautions and the facility doesn't give adaptive dining equipment to residents when they are on transmission based precautions. Resident #3's nutrition care plan, revised 11/11/2024, stated, .a nutrition risk related to .legally blind .use of adaptive equipment at meals . and an intervention, revised 2/6/2025, Scoop plate and two handled cup for meals, assist with tray set-up, orientation to food on tray. Review of Resident #3's physician order, active date 3/5/25-3/12/25, stated, Isolation precautions: Droplet precautions every shift for Suspected influenza for 7 Days. 47659 Resident #4 Review of an Admission Record revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 1 diabetes. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 2/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #4 was moderately cognitively impaired. Review of Resident #4's Care Plan revealed, I (Resident #4) have a nutritional problem or potential nutritional problem . uses adaptive equipment .legally blind- food in bowls to promote self feeding . Date initiated: 11/19/24. Interventions: OT (Occupational Therapy) to screen and provide equipment for feeding as needed; uses blue handled built up utensils, food in bowls. Date initiated: 2/19/25 . During an interview on 03/10/25 at 2:32 PM, Resident #4 reported that he was frustrated that the facility had not been providing him with his adaptive silverware and bowls since he was placed in isolation precautions. Resident #4 reported that the facility told him that he could not have them in isolation, and so he had been struggling to eat his food. During an observation and interview on 3/11/25 at 9:10 AM, Resident #4 was sitting in his room attempting to eat breakfast. Resident #4 had two fried eggs and oatmeal in a styrofoam container. Resident #4 was attempting to use a plastic fork to eat his eggs, and was unable to get the eggs onto his fork. Resident #4 dropped one egg with yolk onto his laptop, and said see this is why I need my silverware. I can't use the plastic stuff. During an interview on 3/12/25 at 9:14 AM, Occupational Therapist (OT) DD reported that it was recommended by therapy for Resident #4 to use adaptive silverware and have his food placed in bowls to assist with his visual deficits and knowing where things were. OT DD reported that staff should always be giving Resident #4 his adaptive silverware and meals in bowls. 48637 During an interview on 3/11/2025 at 1:39 PM, Dining Services Manager (DSM) R stated when a resident was in isolation, paper products and plastic utensils are sent out on meal trays. DSM R also said adaptive cups and utensils aren't sent out during the time of isolation to prevent infection from spreading. DSM R stated Certified Nursing Assistants (CNAs) should be helping to assist those residents that need adaptive equipment during that time. During an interview on 3/11/2025 at 2:01 PM, Assistant Director of Nursing who was also the Infection Preventionist (IP) G stated when a resident was in isolation, foam containers, foam trays and disposable cups and utensils are sent out at meals. IP G said any adaptive equipment such as cups and utensils should be sent out along with a plastic bag from the kitchen for CNAs to put the cups and utensils in the bag after use, and to send them back to the kitchen for cleaning and disinfecting. Review of the Centers for Disease Control and Prevention's 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, found at https://www.cdc.gov/niosh/docket/archive/pdfs/niosh-219/0219-010107-[NAME].pdf, stated, Part II: Fundamental elements needed to prevent transmission of infectious agents in healthcare settings .II.M. Dishware and eating utensils .The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils . (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's adaptive dining equipment policy, dated reviewed/revised 3/12/25, stated, Residents requiring assistance in feeding are potential candidates for .adaptive utensil use, as determined by the occupational therapist .Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray, for sanitization.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to prepare and store food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During a tour of the walk-in cooler, at 10:40 AM on [DATE], it was observed that a 3 gallon container of chicken breast, and two single gallon containers of rice and gravy, were found in the walk in cooler dated for , d+[DATE]. The containers were found with noticeable condensation on the inside with a temperature of 42F. An interview with Dining Services Manager (DSM) R found that staff should log cooling when it is done. An interview with [NAME] YY, at 10:43 AM on [DATE], found that the chicken breasts were cooked yesterday and left out on the counter for awhile until she placed them in the cooler. When asked if she logged any times or temperatures to ensure the food properly cooled, [NAME] YY stated no. A record review of the Kitchen Policy 6.004 Food Safety and Infection Control, dated [DATE], found that 8. A Cooling Log must be utilized to track all cooling potentially hazardous food items. According to the 2017 FDA Food Code section ,d+[DATE].14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . According to the 2017 FDA Food Code section ,d+[DATE].15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S ,d+[DATE].14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph ,d+[DATE].11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During a tour of the clean utensil drawers, at 10:52 AM on [DATE], an interview with DSM R found that staff clean the drawers out weekly. Observation of the mechanical scoop drawer found two scoops with heavy stuck on dried yellow food debris. During a tour of the dining room drink station, at 11:23 AM on [DATE], observation of the underside corners of the juice dispenser found dried splatter. Observation of the pop dispensers found an accumulation of debris on the underside spout for tea. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the east Nourishment room, at 11:43 AM on [DATE], it was found that an accumulation of food and dried debris was evident in the microwave. According to the 2017 FDA Food Code section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During a tour of the cook line, at 10:53 AM on [DATE], it was observed that an open container of grape jelly was found on the preparation counter. Review of the product found that it stated Refrigerate After Opening. According to the 2017 FDA Food Code section ,d+[DATE].16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S,d+[DATE].19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in ,d+[DATE].11(B) or reheated as specified in ,d+[DATE].11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less. During a tour of the walk-in cooler, at 10:34 AM on [DATE], it was observed that a large container of hard-boiled eggs was found dated ,d+[DATE] to ,d+[DATE]. When asked if that was an appropriate dating of the item. DSM R stated it shouldn't be that long. During an observation of the three-door cooler, at 10:48 AM on [DATE], it was observed that a box of nutritional shakes were found half full. When asked how they keep track of these nutritional supplements, DSM R stated that they usually put a date on the box, but as of late we have been going through them so quick they don't last very long. Delivery date on the box stated [DATE]. Review of the product states its good for 14 days after thaw. During a tour of the [NAME] Suite, at 11:31 AM on [DATE], it was found that an open container of flavored thickened water was found with no date, Item states its good for seven days after opening. A container of chicken soup leftovers were found dated for [DATE]. During a tour of the East Suite, at 11:41 AM on [DATE], observation of the refrigeration unit found a leftover container of cheese bread with no date, a leftover container of spaghetti dated [DATE], and an open package of bologna wrapped in paper towel with no date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2017 FDA Food Code section ,d+[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in ,d+[DATE].17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in ,d+[DATE].17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . During a tour of the ice machine area in the main kitchen, at 11:08 AM on [DATE], an interview with DSM R found that the facility uses coolers for ice dispensing on the halls. Observation of the coolers found that they did not allow for self-draining of the ice and instead would allow for water to gather and mix with the ice in the coolers as they melted. According to the 2017 FDA Food Code section ,d+[DATE].12 Storage or Display of Food in Contact with Water or Ice.(B) Except as specified in (C) and (D) of this section, unPACKAGED FOOD may not be stored in direct contact with undrained ice . 38666 During an observation on [DATE] at 11:46 AM, in the activity/dining room across from room [ROOM NUMBER] inside the cabinet on the wall were expired food items. The expired shelf stable items observed were two peach fruit cups dated, Best By [DATE] and Best By [DATE]. There were also mixed fruit cups expired and dated, Best By [DATE], Best by: 20240919 ([DATE]), Best By [DATE], Best By [DATE], and best by: 20250210 (February 10, 2025). During an interview on [DATE] at 11:55 AM, Licensed Practical Nurse C confirmed the fruit cups found in the activity/dining room cupboard were expired and she discarded them in the trash. During an observation on [DATE] at 12:09 PM, in the nourishment room near the central nurses' station in the top left shelf of the supplement cupboard there were two expired [Brand Name] nutritional supplement puddings dated, EXP (expired) BY 29 [DATE] and EXP BY 14 [DATE].

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47659 Based on interview and record review, the facility failed to ensure that Quality Assessment and Process Improvement (QAPI) meetings had the Medical Director as a mandatory attendee at least quarterly resulting in the potential for the Medical Director to not be notified of quality deficiencies occurring in the facility. Findings include: During an interview on 3/12/25 at 1:35 PM, Nursing Home Administrator (NHA) A reported that he had been the interim NHA since 2/2025. NHA A reported that facility had recently changed their QUAPI meetings to quarterly and adding an ad hoc (when necessary) when they determined a need to meet. NHA A reported that the facility had an ad hoc QUAPI meeting on 3/6/25 which Medical Director (MD) JJ attended. NHA A was able to provide a sign in sheet to verify MD JJ's meeting attendance for 3/6/25. When this writer asked to review the sign in sheets for the facility's quarterly QUAPI meetings in the past year, NHA A reported that he did not know where they were and that he would need to look for them. In a follow up interview on 3/12/25 at 2:35 PM, NHA A was able to provide documentation of sign in sheets that confirmed MD JJ attended QUAPI meetings on 7/23/2024, 8/27/2024, and 2/25/2025. NHA A reported that after August 2024, the facility switched to meeting quarterly instead of monthly. NHA A reported that he had confirmed with MD JJ that he did not attend the facility's next quarterly QUAPI meeting in November 2024. NHA A reported that Nurse Practitioner (NP) WW attended the November 2024 meeting, but that he was unable to locate a sign in sheet for this meeting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38666 Based on observation, interview, and record review the facility failed to: 1.) use appropriate personal protective equipment for enhanced barrier precautions and/or appropriate infection control practices for 2 (Resident #38 and #42) of 3 residents reviewed for high contact care activities and catheter care and 2.) don appropriate personal protective equipment for 1 (Resident #27) of 5 residents reviewed for transmission based precautions, resulting in the potential for spread of infection.Findings include: Resident #27 During an observation and interview on 03/10/25 at 11:16 AM, Hospice Registered Nurse (RN) RR was observed entering Resident #27's room whose door had a transmission based precaution sign indicating the room was under droplet precautions. The droplet precaution signage on the door stated, Droplet Precautions .EVERYONE MUST: .Make sure their eyes, nose and mouth are fully covered before room entry and had pictures showing use of a face shield or appropriate eye goggles. This sign was noted to be produced by the Centers for Disease Control and Prevention. Hospice RN RR entered the droplet precaution room wearing only a surgical mask with no eye protection. When Hospice RN RR exited the resident room Hospice RN RR confirmed no personal protective equipment was put on except for the surgical mask. During an interview on 03/10/25 at 11:26 AM, Unit Manager FF reported to enter a droplet precaution room one must put on a gown, mask, and eye protection noting the mask should be an N95 (mask/respirator). During an observation on 03/10/25 at 11:42 AM, Hospice Aide SS was observed entering Resident #27's room with that had a droplet precaution sign on the door indicating a mask and eye protection must be worn to enter. Hospice Aide SS entered the room wearing a gown, surgical mask, and personal eyeglasses (not an approved piece of personal protective equipment for the eyes). Review of the facility's infection control policy, revised 3/10/25, stated, Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC (Centers for Disease Control and Prevention) guidelines. Review of the Centers for Disease Control and Prevention's droplet precaution signage, https://www.cdc.gov/infection-control/media/pdfs/droplet-precautions-sign-P.pdf, undated, stated, Droplet Precautions . EVERYONE MUST: .Make sure their eyes, nose and mouth are fully covered before room entry .(and included two infographics showing a person wearing a face shield or a goggle/eye protector). 36221 Resident #38 Review of an Admission Record revealed Resident #38 was a female, with pertinent diagnoses which included Parkinson's disease, dementia, diabetes, high blood pressure, and muscle weakness. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current Care Plan for Resident #38 revealed the focus .Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO). The resident must be placed in isolation (enhanced) due to the resident at risk of spreading MDRO's via an indwelling device, chronic/non healing wound . with interventions which included .Staff are to wear PPE (Personal Protective Equipment) before entering room if they are providing high contact care . both initiated 6/17/24. Review of an Order Summary Report for Resident #38 revealed the active physician order .Enhanced Barrier Precautions are in place to prevent the spread of MDRO's every shift for Safety All staff are to wear Gown and Gloves when providing high contact care . with a start date of 6/17/24. In an observation on 3/11/25 at 1:32 PM, Certified Nursing Assistant (CNA) NN and CNA Q entered Resident #38's room to assist her with bed mobility prior to the lunch meal. Noted signage on Resident #38's door indicating Enhanced Barrier Precautions were in place. Observed CNA NN and CNA Q don gloves prior to repositioning Resident #38 and boosting her up in bed. No gowns were utilized by CNA NN and CNA Q while assisting Resident #38 with bed mobility. Noted both CNA's clothing came into contact with Resident #38's bed linens multiple times throughout care. In an observation on 3/11/25 at 3:02 PM, Registered Nurse (RN) H and Hospice RN RR entered Resident #38's room to complete wound care. Noted signage on Resident #38's door indicating Enhanced Barrier Precautions were in place. Observed RN H and Hospice RN RR don gowns and gloves prior to completion of wound care for Resident #38. Observed RN H remove and discard her gown and gloves and exit the room to obtain additional wound supplies for Hospice RN RR. Upon returning to Resident #38's room, RN H donned gloves but no gown. When wound care was complete, RN H assisted Hospice RN RR with repositioning Resident #38 and a brief change. Noted RN H did not wear a gown while assisting Resident #38 with bed mobility and a brief change. Observed Resident #38 pulling on RN H's shirt collar while being repositioned in bed. In an interview on 3/11/25 at 3:19 PM, RN H reported gowns and gloves were only required to be worn when performing catheter care or wound care for Resident #38. RN H reported gown use was not indicated with bed mobility or brief changes for a resident on Enhanced Barrier Precautions. In an interview on 3/12/25 at 9:20 AM, CNA UU reported Enhanced Barrier Precautions (gowns and gloves) were only required for Resident #38 when completing catheter care. In an interview on 3/12/25 at 1:44 PM, Infection Preventionist G reported for residents on Enhanced Barrier Precautions, gowns and gloves were required for any high contact resident care, which included brief changes and bed mobility. 47659 Resident #42 Review of an Admission Record revealed Resident #42 was originally admitted to the facility on [DATE] with pertinent diagnoses which included obstructive and reflux uropathy (a condition where urine flow is blocked and can back up in the kidneys). (continued on next page)

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	03/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #42's Care Plan revealed, I have an indwelling catheter: Neurogenic bladder (a condition that occurs when the nervous system connection to the bladder is disrupted, causing bladder control issues). Date initiated: 10/4/24. Interventions: Monitor for s/s (signs and symptoms) of discomfort on urination and frequency. Date initiated: 10/4/24 . Review of Resident #42's Orders revealed, Flush foley catheter with 60 ml (milliliters) of normal saline once daily. Start date: 12/16/24. During an observation on 3/10/25 at 2:16 PM, Resident #42 was lying in his bed. Resident #42's catheter was attached to his bed and the bottom of the catheter bag was sitting on the floor. Heavy sediment was noted in Resident #42's catheter tubing. During an observation on 3/11/25 at 1:41 PM, Registered Nurse (RN) O entered Resident #42's room with medications and supplies to flush Resident #42's catheter. RN O placed all of the supplies on Resident #42's tray table. It was noted that Resident #42's tray table was visibly soiled with some kind of liquid. RN O proceeded to give Resident #42 his oral medication and administer insulin into Resident #42's arm. After administering medications, it was noted that RN O adjusted Resident #42's blanket. It was noted that Resident #42's blanket was soiled with several pieces of food and paper. RN O then prepared to flush Resident #42's catheter by opening the saline solution to place into the syringe. It was noted that RN O did not wash her hands or change her gloves prior to handling the syringe. RN O then used the syringe to flush Resident #42's catheter. After RN O flushed Resident #42's catheter, she then grabbed antiseptic wipes and began to wipe the tip of Resident #42's penis. It was noted that RN O did not change her gloves or wash her hands prior to wiping Resident #42's penis. During an interview on 3/12/25 at 10:06 AM, Infection Preventionist (IP) G reported that she had not recently completed any catheter care education or audits of catheter care with staff. IP G reported that nurses were expected to wash their hands prior to completing care, and that if the nurse had to touch anything that is soiled, they should change their gloves prior to completing catheter care.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to ensure COVID-19 consents or declinations were obtained for 1 resident (Resident #71) of 5 residents reviewed for immunizations resulting in residents/family members not being aware of the vaccination and the risks/benefits of having it administered. Findings include: Resident #71(R71) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R71 admitted to the facility on [DATE] with diagnoses including type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) and surgery of the digestive system. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which indicated R71 was severely cognitively impaired (00 to 07 is severe cognitive impairment). Review of R71's immunization record revealed that COVID-19 wasn't listed and as a result it was unknown whether R71 received or refused the vaccine. Review of the facility list titled Covid Vaccine Resident List dated 10/24 (2024) revealed Consent: Yes; Refused: Refused. Further review of R71's medical record revealed that R71 had a guardian due to her cognition status. There was no documentation that R71's guardian was contacted regarding consent or declination of the COVID-19 vaccination nor that education on the risks/benefits was given. During an interview on 3/11/2025 at 2:15 PM, Assistant Director of Nursing who was also the Infection Preventionist (IP) G reviewed R71's chart and could not locate the consent/ declination of the COVID vaccination and could not find documentation that her guardian was called and educated on the risks/benefits of the vaccine. Review of the COVID-19 Vaccination Policy with a review date of 3/10/2025 revealed Policy Explanation and Compliance Guidelines . 14. The facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such 17. Residents or their representatives and staff will sign the consent form prior to administration of the COVID-19 vaccine. This information will be retained in the resident's medical record or the staff's medical file .21. The resident's medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal.