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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235057	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Livonia	28550 Five Mile Rd Livonia, MI 48154

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on interview and record review, the facility failed to ensure one resident (R86) of one resident reviewed, was referred to with dignity regarding potentially deogatory language. Findings Include: A review of the record for R86 revealed an order entered by Licensed Practical Nurse (LPN) B dated 03/07/24 which documented, Assist feeder for all meals. The record further documented R86 was admitted into the facility 02/27/24. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented, severely impaired cognition and substantial/maximal assistance for Activities of Daily Living. On 12/09/24 at 1:20 PM, LPN B was queried about the order and reported the order using the word feeder was not appropriate and should have read 'assist with all meals' or 'one to one assist with all meals'. On 12/10/24 at 11:52 AM, the Director of Nursing (DON) confirmed the term 'feeder' should not have been used. A review of the policy titled, Dignity dated 01/02/24 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.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 Based on interview and record review the facility failed to ensure a care plan was updated to reflect fall interventions for one sampled resident (R10) of three reviewed for accidents. Findings include: On 12/08/24 at 9:10 AM, R10 was observed to sit on the side of their bed. R10 right eye was observed with a discolored ring around the lower part of the eye. R10 was asked about the bruise on their eye. R10 explained they fell out of bed while they were asleep. R10 explained they hit their face on the night stand and landed face down on the floor. The environment around R10's bed was observed with some clutter. R10 was asked if the facility put things in place to try and prevent them from falling out of bed again. R10 said they didn't think so. A review of R10's incident and accident reports noted three falls: on 07/1/24, 11/09/24 and 11/12/24, all three were due to self transfer. On 12/10/24 at 12:25 PM, the Director of Nursing (DON) was asked if after each fall there was a review of the falls along with intervention revisions and the DON explained the facility found they had not been completing the necessary steps after the resident falls. A review of R10's medical record noted, R10 was readmitted to the facility on [DATE] with diagnosis of Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side. A review of R10's Minimum Data Set (MDS) assessment noted R10 with an intact cognition and required assistance by staff for activities of daily living. A review of R10's care plan revealed, Focus: Requires supervision at times for transfers. Resident is non-compliant (with) self transfers. Date Initiated: 01/07/2021. [R10] is at risk for falls or fall related injury history of falls, left-sided hemi, epilepsy, major depressive disorder, use of opioid medication, use of antidepressants, pain in left hip, osteoarthritis, clutter on bed and at bedside. Date Initiated: 05/12/2023. The last documented revision in the care plan for falls was 05/12/23. On 12/10/2024 at 3:59 PM, a request was made for the facility's policy regarding care plan revision. The Nursing Home Administrator (NHA) reported via email on 12/10/24 at 4:46 PM that the facility does not have a specific policy for revisions to care plans after falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Fall Prevention dated, 1/2/24 noted, Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls . 7. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 This citation has two deficient practice statements. Deficient Practice Statement #1: Based on observation, interview, and record review, the facility failed to provide showers for one (R8) of four residents reviewed for hygiene. Findings include: On 12/08/24 at 9:16 AM, R8 was observed in bed and appeared not to be dressed or cleaned up for the morning. R8 was asked about daily care and any related concerns and reported they hadn't had a shower in over a month. R8 reported when they ask staff about having a shower they are told their shower days are on Monday and Thursday, but on those days nobody offers a shower or they are told it can't be done for some other reason. Review of the facility record for R8 revealed an original admitted [DATE] diagnoses included Cardiac Arrest and Heart Failure. R8's Care Plan dated 11/27/24 indicated R8 was incontinent, non-ambulatory, and required assistance with bathing. Review of the electronic medical record (EMR) and paper shower sheets from 11/03/24 to 11/25/24 revealed a total of seven opportunities with two showers documented as offered and refused. No additonal showers were documented. On 12/10/24 at 12:45 PM, the Director of Nursing (DON) reported the resident should be offered a shower twice weekly on their scheduled shower days and as needed. Review of the facility policy Activities of Daily Living dated 01/02/24 revealed the policy statement that included Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care. The Procedure portion of the policy included the statement 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 50223 Deficient Practice Statement #2. Based on observation, interview, and record review the facility failed to provide meal assistance for one resident (R38) out of six residents reviewed for Activities of Daily Living (ADLs). Findings include: R38 On 12/08/24 at 10:14 AM, 11:31 AM, 1:14 PM and 3:53 PM, R38 was observed lying in bed on their back with the head of the bed slightly elevated. A full bottle of chocolate nutritional drink was observed on the overbed table with a straw in it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 8:55 AM, R38 was observed lying in bed, snoring with their mouth open, on their back with the head of the bed elevated approximately 45 degrees. A breakfast tray was observed positioned in front of them on the overbed table consisting of full amount of french toast which was cut into cubes and ground bacon. At 10:00 AM, the meal tray was observed and the meal had not been eaten. On 12/09/24 at 12:02 PM, R38 was observed in the dining room sitting in their wheelchair. An unidentified staff member delivered R38's lunch tray, removed the cover from the plate and placed a straw in a cup of red liquid. The lunch was observed to consist of a small bowl of salad (lettuce, chunks of tomatoes, and shredded cheese), a bowl of chicken pot pie, and a bowl of fruit chunks in a white sauce. On 12/09/24 at 12:09 PM, an unidentified staff member was observed to sit down at the table where R38 was sitting and assisted another unidentified resident with their meal. At 12:11 PM, R38 was observed eating lettuce out of the bowl of salad one by one with their fingers. At 12:21 PM, the staff member finished feeding the other unidentified resident and left the table. At 12:24 PM, Nurse Practitioner (NP L) spoke to R38 and after R38 picked up a piece of lettuce with their fingers NP L handed them a spoon. On 12/09/24 at 12:37 PM, another unidentified staff member removed R38's lunch tray. R38's lunch tray was observed with a few pieces of lettuce missing, half of the fruit cup eaten, the chicken pot pie remained intact. On 12/10/24 at 8:44 AM R38 was observed lying in bed on their back with the head of their bed slightly elevated. R38 responded no when asked if they already eaten breakfast. At 8:47 AM, R38's breakfast tray was observed in the dirty meal cart. The meal ticket indicated the following: scrambled eggs with cheese 1/4 cup, biscuit, 8 oz milk, 4 oz orange juice, butter, jelly. The plate contained all of the scrambled eggs, a full bowl of oatmeal, a biscuit which had a few pieces missing, a full carton of milk, and a cup containing a small amount of orange juice. A review of R38's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Alzheimer's disease unspecified. A review of R38's Brief Interview for Mental Status (BIMS) revealed a score of 2/15 which indicated severe cognitive impairment. A review of R38's physician orders revealed the following: Diet downgraded. Speech consult. Dated 12/8/24.; Regular diet, dysphagia mechanical texture, regular consistency 1:1 Assist feed dated 12/8/24. Nutritional shake three times a day for supplementation. Give with meals. Dated 8/30/24. A physician progress note dated 12/2/24 revealed the following: Thin cacectic (physical wasting, weight loss) appearing .patient has high risk for developing contractures, pressure ulcers, poor healing or fall if not recieved adequate therapy .Patient chart indicates patient with increased difficulty with intake and self feeding. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R38's care plan revealed the following: (R38) needs assistance with activities of daily living. Resident will have care needs met daily with assistance of staff. Eating: 1:1 assist feeding .R38 presents with potential for nutritional risk related to poor appetite with failure to thrive, R38 will have a weight increase closer to IB (ideal body weight) range through next review. Provide and serve diet as ordered. Provide and serve supplements as ordered. A review of R38's record revealed the following weights: 11/5/24 =75.6 lbs (pounds); 12/6/24 =73.5 lbs. Further review of R38's record revealed a Nutrition Data Collection Review dated 11/28/24 which revealed the following: Regular diet, regular texture, regular consistency 1:1 Assist feed. Nutritional shake TID (three times per day) .(R38) remains underweight per BMI .Staff assist at meals. On 12/10/24 at 8:54 AM, during an interview, Licensed Practical Nurse (LPN A) confirmed R38's diet order states 1:1 feed. On 12/10/24 at 9:11 AM, during an interview, Certified Nurse Assistant (CNA P) explained R38 needed extensive assistance, and they eat pretty well when they have help and encouragement. CNA P confirmed R38 gets a nutritional supplement with meals. On 12/10/24 at 12:42 PM, the Director of Nursing (DON) said her expectation is if R38's order says 1:1 feed that R38 should be individually supervised and assisted throughout the entirety of the meal. A review of the facility policy titled Activities of daily living (ADLs) revealed the following: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: . 4. Eating to include meals and snacks . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition . 5. The facility will maintain individual objectives of the care plan and periodic review and evaluation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 This citation has two deficient practices. Deficient Practice Statement #1: Based on observation, interview, and record review, the facility failed to ensure lower extremity lymphedema wraps (elestic bandage wrap applied to reduce swelling) were applied for one (R72) of four residents reviewed for care. Findings include: On 12/08/24 at 10:02 AM, R72 reported their legs hadn't been wrapped for edema for the past two days. R72's legs were visible, and no wraps were in place. Review of R72's facility record revealed an admitted [DATE] with diagnoses included Heart Failure and Bilateral Lower Extremity Swelling. A physician order dated 12/3/24 documented: Wrap bilateral lower extremities with (name of elastic bandage) wrap daily and remove at HS (bedtime). Related to Lymphedema. On 12/09/24 at 1:20 PM, R72 was interviewed in their room. Their legs were visible and not wrapped. They were asked if their legs were ever wrapped yesterday or earlier today and they stated No. R72 reported they were concerned about it because they were experiencing increased swelling recently and they were afraid it may affect their progress in therapy. On 12/10/24 at 12:36 PM, the Director of Nursing (DON) reported the wraps should be applied daily as ordered. Review of the facility policy Physician Orders dated 01/02/24 revealed: . The policy defines professional standards of quality as care and services are provided according to accepted standards of clinical practice . 50223 Deficient practice statement #2. Based on observation, interview, and record review, the facility failed to reposition one resident (R38) out of five residents reviewed for mobility. Findings include: On 12/08/24 at 8:55 AM, 10:14 AM, and at 11:31 AM, R38 was observed lying in bed on their back sleeping with the head of the bed slightly elevated wearing a hospital gown. No positioning wedge was observed in the room. On 12/08/24 at 1:14 PM, and 3:53 PM, R38 was observed still lying in bed on their back with the head of the bed slightly elevated leaning to the right with their head off the bed. No positioning wedge was observed in the room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 8:55 AM and 3:52 PM, R38 was observed lying on their back in bed wearing a hospital gown with the head of the bed slightly elevated. No positioning wedge was observed in the room. On 12/10/24 at 8:44 AM R38 was observed lying in bed on their back with the head of the bed slightly elevated. No positioning wedge was observed in the room. A review of R38's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Alzheimer's disease unspecified. A review of R38s Brief Interview for Mental Status revealed a score of 2 which indicated severe cognitive impairment. A review of R38's careplan revealed the following: (R38) needs assistance with activities of daily living. Resident will have care needs met daily with assistance of staff. BED MOBILITY: One staff assistance . Resident has impaired skin integrity stage 2 (partial thickness wound) to coccyx (tailbone). Tissue injury will heal an be free from complications. Assist with bed mobility to turn and reposition routinely .Resident is at risk for skin breakdown. Resident will be free from skin breakdown. Assist with bed mobility to turn and reposition routinely. On 12/10/24 at 8:54 AM, during an interview, Licensed Practical Nurse (LPN A) confirmed R38 needs assitance with activities of daily living (ADLs) and is not able to reposition themself in bed. On 12/10/24 at 9:11 AM, Certified Nurse Assistant (CNA P) explained R39 is not able to move themselves around in bed and they require extensive assistance. CNA P explained R39 needs to be repositioned by staff every two hours and that R38 does not have a positioning wedge. 12/10/24 12:42 PM, the Director of Nursing (DON) explained R39 should have a positioning wedge and be repositioned every two hours. A review of the facility policy titled Activities of daily living (ADLs) revealed the following: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .5. The facility will maintain individual objectives of the care plan and periodic review and evaluation.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview, and record review, the facility failed to apply hand splints for one resident (R38) out of five residents reviewed for mobility and range of motion. Findings include: On 12/08/24 at 8:55 AM, 10:14 AM, and at 11:31 AM, 1:14 PM, and 3:53 PM, R38 was observed lying in bed on their back sleeping with the head of the bed slightly elevated wearing a hospital gown. R38s hands appeared contracted. A hand splint was observed on the night stand. On 12/09/24 at 8:55 AM, R38 was observed lying their back in bed wearing a hospital gown with the head of the bed slightly elevated. The hand splint was observed in the same place on the night stand as previously observed. On 12/09/24 from 12:09 PM until 12/09/24 12:37 R38 was observed in their wheelchair in the dining room wearing a hand splint on their left hand and was observed eating with difficulty. A splint was not observed on their right hand. On 12/10/24 at 8:44 AM R38 was observed lying in bed on their back in bed with the head of the bed slightly elevated. The hand splint was observed on the night stand. R39 was asked if they were able to open their hand. R38 lifted their left hand and was observed to try to open it unsuccessfully. A review of R38's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Alzheimer's disease unspecified. A review of R38s Brief Interview for Mental Status revealed a score of 2 indicating severe cognitive impairment. A review of R38's physician orders revealed the following: Lambs wool splint on left hand: place on thumb in palm, strap on back. Gel splint on right hand: slip on similar to a glove. Take off for hygiene. A Occupational Therapy (OT) progress note dated 11/26/24 revealed the following: wool palm protector placed on L(left) and gel palm protector place on R (right) to promote skin integrity and functional use of R hand. Orthotic information form with instructions provided for nursing. A physician progress note dated 11/27/2024 revealed the following: .has a left hand contracture . (R38) continues working with ST (speech therapy)/OT, have wool palm protector placed on L and gel palm protector place on R to promote skin integrity and functional use of R hand. On 12/10/24 at 8:54 AM, during an interview Licensed Practical Nurse (LPN A) explained R38 has a lambs wool thing for their hand which is applied at 10:00 AM. LPN A confirmed after reviewing R38's medial record the splints should be on, and only taken off for hygiene. On 12/10/24 at 9:30 AM, during an interview, the Physical Therapy Director (PT O) explained R38 has 2 palm protectors one is lambs wool and the other one is a gel glove to protect R38's hand from their nails. PT O confirmed the palm protectors should only be taken off for hygiene and otherwise should always be on. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/10/24 12:42 PM, during an interview, the Director of Nursing (DON) confirmed R38s hand splints should be on all the time and only taken off for hygiene. A review of the facility's policy titled Assistive Devices revealed the following: POLICY. The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. PROCEDURE 1. Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. They may help the individual move around, see, communicate, eat, or get dressed. Assistive devices include: . f. Orthotic or prosthetic equipment. 2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care. 3. The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement. 4. Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices. This may include education or therapy sessions for training on the use of the device, set up assistance, supervision, or physical assistance as needed. 5. Direct care staff will be trained on the use of the devices as needed to carry out their roles and responsibilities regarding the devices. Training will also include when to refer to other departments for changes in condition or problems with the device.6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 This citation has two deficient practice statements. Deficient practice #1. Based on observation, interview, and record review, the facility failed to provide tube feeding (TF-feeding supplied through a tube into the stomach) and hydration for one resident (R346) out of three residents reviewed for tube feeding. Findings include: On 12/09/24 at 09:50 AM, 10:12 AM, 11:27 AM, and 3:54 PM, R346 was observed lying in bed. R346's TF bottle contained 400ml (milliliters) and was dated 12/8/24. The TF and water flush was not connected to R346 and was not infusing. On 12/10/24 at 08:51 AM R346 was observed being pushed back to their room in a wheelchair by an unidentified staff member. R346's TF bottle was still dated 12/8/24, still contained 400ml, and was still not infusing. A review of R346's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Acute and Chronic respiratory failure with hypoxia (low oxygen level); dysphagia (difficulty swallowing), unspecified; legal blindness. R346's Brief Interview for Mental Status revealed a score of 15 indicating intact cognition. A review of R346's physician orders revealed the following: Enteral Feed order two times a day. Continuous feeding formula: Nepro 65ml/hour (hr) for 20 hours. On: 1400 (2 PM) off: 1000 (10 AM) total volume 1300mls. Enteral feed order every shift automatic water flush 30ml/hr. A review of R346's care plan revealed the following: (R346) is at risk for complications due to requires tube feeding related to dysphagia, NPO (nothing by mouth) status. Therapeutic tube feeding for ESRD (end stage renal disease) on HD (hemodialysis) underweight per BMI (body mass index). R346 will be free from complication of the tube feeding. R346 will have a weight increase closer to IBW (ideal body weight) range through next review. Tube feeding and water flushes as per MD (medical doctor) orders. On 12/10/24 at 08:54 AM, during an interview Licensed Practical Nurse (LPN) A explained R346's tube feeding runs for 20 hours from 2 pm until 10 am. LPN A said R346 was not currently getting the tube feeding due to going to physical therapy but that they would restart it when R346 returned. LPN A confirmed the TF bottle was from 12/8/24 and the feeding was not infused last night. On 12/10/24 at 09:22 AM R346 was observed lying in bed. R346 was asked if they had received their TF last evening, to which they said, the TF was not working last night. RR346 said they have been feeling hungry since yesterday . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Majestic Care of Livonia		STREET ADDRESS, CITY, STATE, ZIP CODE 28550 Five Mile Rd Livonia, MI 48154	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 10:44 AM, during an interview the Registered Dietician (RD M) explained the tube feeding formula and duration it infuses is calculated based on the residents' caloric needs. RD M said if there was an issue with the tube feeding the order should have been changed to make up for the calories the resident needs. On 12/10/24 at 12:42 PM, during an interview the Director of Nursing (DON) confirmed R346 should receive tube feeding as ordered. A review of the facility's policy titled Enteral Feeding revealed the following: POLICY. It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. PROCEDURE1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush . 3. The resident's plan of care will address the use of feeding tube, including strategies to prevent complications. 4. The facility will utilize the Registered Dietitian in estimating and calculating a resident's daily nutritional and hydration needs . Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided: a. Types of enteral nutrition formulas available for use. b. How to determine whether the tube feedings meet the resident's needs and when to adjust them accordingly. c. How to balance essential nutritional support with efforts to minimize complications related to the feeding use . e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders. Deficient practice #2. Based on observation, interview, and record review, the facility failed to provide meal assistance and nutritional supplements for one resident (R38) out of six residents reviewed for Activities of Daily Living (ADLs). Findings include: On 12/08/24 at 10:14 AM. 11:31 AM, 1:14 AM and 3:53 PM, R38 was observed lying in bed on their back with the head of the bed slightly elevated. A full bottle of chocolate nutritional drink was observed on the overbed table with a straw in it. On 12/09/24 at 8:55 AM, R38 was observed lying in bed, snoring with their mouth open, on their back with the head of the bed elevated. A breakfast tray was observed positioned in front of them on the overbed table consisting of full amount of french toast which was cut into cubes and ground bacon. No nutritional drink was observed on the tray or in R38's room. On 12/09/24 at 12:02 PM, R38 was observed in the dining room sitting in their wheelchair. An unidentified staff member delivered R38's lunch tray, removed the cover from the plate of and placed a straw in a cup of red liquid. No nutritional supplement was provided. On 12/09/24 at 12:09 PM, An unidentified staff member was observed to sit down at the table where R38 was sitting and assisted another unidentified resident with their meal. On 12/09/24 at 12:21 PM, the staff member finished feeding the other unidentified resident and left the table. (continued on next page)

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Majestic Care of Livonia	28550 Five Mile Rd Livonia, MI 48154

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 8:44 AM R38 was observed lying in bed on their back with the head of their bed slightly elevated. R38 responded no when asked if they already ate breakfast. On 12/10/24 at 8:47 AM, R38's breakfast tray was observed in the dirty meal cart in the hallway. The meal ticket indicated the following: scrambled eggs with cheese 1/4 cup, biscuit, 8oz milk, 4oz orange juice, butter, jelly. The tray contained all of the scrambled eggs, a biscuit which a few pieces were missing, an 8oz carton of milk that was open but full, and a cup containing a small amount left of orange juice. The tray also contained a full bowl of oatmeal. A nutritional supplement was not observed on the tray nor in the resident's room. A review of R38's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Alzheimer's disease unspecified. A review of R38s Brief Interview for Mental Status revealed a score of 2 indicating severe cognitive impairment. A review of R38's physician orders revealed the following: Diet downgraded. Speech consult. Dated 12/8/24.; Regular diet, dysphagia mechanical texture, regular consistency 1:1 Assist feed dated 12/8/24. Nutritional shake three times a day for supplementation. Give with meals. Dated 8/30/24. A review of R38's care plan revealed the following: (R38) needs assistance with activities of ail living. Resident will have care needs met daily with assistance of staff. EATING: 1:1 assist feeding .R38 presents with potential for nutritional risk related to poor appetite with failure o thrive, R38will have a weight increase closer to IB (ideal body weight) range through next review. Provide and serve diet as ordered. Provide and serve supplements as ordered. A review of R38's record revealed the following weights: 11/5/24 =75.6 lbs (pounds); 12/6/24 =73.5 lbs. Further review of R38's record revealed a Nutrition Data Collection Review which revealed the following: Regular diet, regular texture, regular consistency 1:1 Assist feed. Nutritional shake TID (three times per day) . (R38) remains underweight per BMI .Staff assist at meals dated 11/28/24. On 12/10/24 at 8:54 AM, during an interview, Licensed Practical Nurse (LPN A) confirmed R38 should get nutritional drinks three times per day from nursing and R38's diet order states 1:1 feed. On 12/10/24 at 9:11 AM, during an interview, Certified Nurse Assistant (CNA P) explained R38 gets nutritional supplement with meals and were not sure if R38 got one with breakfast that day. On 12/10/24 at 10:44 AM during an interview, the Registered Dietician (RD) explained although R38's weight has fluctuated and they have had some weight loss the loss, the resident should receive nutritional supplements 3 times per day which are ordered by the dietician and is provided by nursing. On 12/10/24 at 12:42 PM, during an interview the Director of Nursing (DON) said the expectation is if R38 should be individually supervised and assisted throughout the entirety of the meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled Nutrition Management revealed the following: A Registered Dietitian will assess the nutritional status of the facility residents at minimum at time of admission, significant change in status and annually. PROCEDURE The resident will be interviewed at admission and at least annually with a focus on physical nutrition identifiers and preferences/needs. The medical history will be reviewed. o Food allergies/intolerances will be identified and confirmed to be notated on the tray card.o An assessment of estimated kcal, protein and fluid needs will be completed with each comprehensive MDS assessment.o The resident's nutritional care plan will be reviewed with each MDS assessment and as needs/interventions change.o Nutrition education/counseling will be provided to residents and staff as needed/desired.o The Dietitian will confer with ST and other therapy disciplines as needed to ensure the least restrictive diet and adaptive ware are followed/available.o The Dietitian will participate in IDT Risk Review at least monthly to provide nutrition assessment/recommendations for those residents determined to be at risk.o The Dietitian will support the Dietary Manager in updating/revising/planning therapeutic diets as needed to meet physician orders and/or nutritional needs of the residents.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation pertains to Intake MI00148624. Based on interview and record review, the facility failed to provide interventions for a resident with PTSD (Post-Traumatic Stress Disorder) to address triggers for one Resident (R44) of one resident reviewed for trauma-informed care. Findings include: On 12/08/24 at 1:00 p.m., R44 reported they had been dealing with their PTSD and felt upset recently, as the facility had attempted to involuntarily discharge them on 11/29/24. R44 revealed their involuntary discharge form, dated 11/29/24, which showed they refused to sign the form. R44 reported they had not been made aware prior of any discharge plan, and this resulted in a traumatic reaction for them. R44 explained they became escalated when they learned about the discharge plan, as they were being discharged to a homeless shelter. R44 stated they had a home before being admitted to the facility, and had given up their apartment when they became a long-term care resident. R44 reported after the (State) Ombudsman became involved, they had a discharge plan to community houseing. R44 explained they had PTSD since they witnessed their family member being shot when they were murdered, and reported they were triggered by loud noises, and were easily startled by changes. Review of R44's social services note, dated 11/29/24 at 12:13 p.m., showed R44 was issued an involuntary discharge notice on 11/29/24. The note confirmed R44 refused to sign the discharge notice, and the discharge destination was a homeless shelter. Review of R44's social services note, dated 11/29/24 at 12:30 p.m., showed, Following IVT (involuntary discharge) being issued, resident began having elevated behaviors: verbal aggression, expressing threats, and throwing paperwork towards writer. Writer attempted to de-escalate behaivors by calmly explaining the IVT and allowing the resident to vent (their) frustrations. Resident continued to have elevated behaviors then eventually went to (their) room. Review of R44's 12/04/24 social services note, dated 12/04/24 at 14:00 (2:00 p.m.) documented R44 met with the Ombudsman to discuss discharge planning. Review of R44's 12/04/24 social service note, dated 12/04/24 at 16:03 (4:03 p.m.) documented R44's IVT had been rescinded, and a discharge plan was put in place including referral to community resouces and a group home or an apartment. Review of R44's Care Plan, accessed 12/09/24, revealed, Resident has a dx (diagnosis) of PTSD. Date initiated: 6/21/2024. Resident will be able to identify feelings of fear with SW (Social Worker) and/or Psych by next reporting period. Target Date: 12/12/2024 . Interventions included .Educating resident to importance of expressing feelings .Provide resident an outlet for expression and identification of feelings on an ongoing basis .Reassure resident that (they are) in a safe environment .Refer to (Provider name) psych services prn (as needed) . There were no interventions which identified any triggers or how to address triggers or potential triggers in R44's trauma care plan. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R44's Social Services assessments revealed no documentation of triggers or potential triggers for their PTSD diagnosis, and how to cope with their triggers, including any PTSD assessment, or effective interventions. Review of R44's behavioral logs for the past month (30-day look-back from 11/09/24 to 12/09/24) showed no behaviors were documented. The Director of Nursing (DON) was asked if there were any behavioral tracking logs for the month prior (10/09/24 to 11/09/24), and reported none were tracked at that time. Review of R44's Minimum Data Set (MDS) assessment, dated 9/13/24, revealed R44 was admitted to the facility on [DATE], with diagnoses including congestive heart failure, peripheral vascular disease (circulatory disorder), seizure disorder, COPD (chronic obstructive pulmonary [lung] disease), and PTSD (Post Traumatic Stress Disorder). The assessment revealed R44 required set up with toileting, dressing, and transfers, and was independent with walking. The Brief Interview for Mental Status (BIMS) assessment showed a score of 15/15, which revealed R44 was cognitively intact. The behavioral assessment revealed no behaviors. On 12/09/24 beginning at 3:48 p.m., the Social Services Director, Staff T, and the Social Services Assistant, Staff U, were interviewed with the Nursing Home Administrator (NHA). The NHA clarified they rescinded the IVT a few days after delivery, and clarified they and the nursing management team were not aware R44 had a PTSD diagnosis until last week. The NHA confirmed there were no interventions in place to address R13's triggers and no PTSD assessment per standards of best practice for trauma-informed care, which would include Care Planning and documentation of triggers and effective interventions. The NHA reported they received calls regarding R44 acting out in the community, such as being intoxicated and acting inappropriately, however they recognized the behaviors in the community were not documented. They reported R44 became agitated with their roommates often and acted out, but was unable to provide documentation. The NHA acknowledged there was room for improvement with documentation and reported their discharge plan was appropriate, as they rescinded the discharge shortly after delivery upon furhter review. On 12/10/24 at 11:51 a.m., the Director of Social Services, Staff T, and the Assistant Director of Social Services, Staff U, were asked if there was a PTSD assessment or any documentation of triggers and effective interventions for R44. Staff U reported there had been an assessment for trauma in a Social Services Assessment when R44 was admitted to the faciltiy however acknowledged there had been no follow-up, PTSD formal assessment, or identification of triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Trauma Informed Care, dated 1/2024, revealed, It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences and address the needs of trauma survivor by minimizing triggers and/or retraumatization. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include but are not limited to: a. Natural and human caused disasters. b. Accidents. c. War. d. Physical, sexual, mental, and/or emotional abuse (past or present), e. Rape, f. Violent crime. g. History of imprisonment. hjj. history of homelessness. i. Traumatic life events (death of a loved one, personal illness, etc.). Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization .4. The facility will collaborate with resident trauma survivors, and as appropriate the resident's family, friends, the primary care physician, and any other health care professionals .to develop and implement individualized care plan interventions .6. The facility will identify triggers which may re-traumatize resident with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan .7. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's needs to be respected, informed, connected, and hopeful regarding their own recovery .The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The residents and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50223 This citation pertains to Intake MI00148803. Based on interview and record review the facility failed to ensure the services of a Registered Nurse (RN) were provided for at least eight consecutive hours per day on the weekend days resulting in the potential for inadequate coordination of emergent or routine care that could cause negative outcomes affecting all 90 residents in the facility. Findings include: Following a review of the nurses' schedule for 4 weeks in the months of November and December 2024, it was revealed there was no documented eight consecutive hours of RN coverage on December 7, 2024. On 12/10/2024 at 1:08 PM, during an interview, the scheduler staff (K) confirmed there was no RN on duty on 12/7/2024. On 12/10/2024 at 2:07 PM, during an email exchange, the Nursing Home Administrator explained they confirmed with the Director of Nursing (DON) that there was no RN coverage on 12/7/2024 and explained the scheduled RN could not work due to illness.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32220 Based on observation, interview and record review the facility failed to ensure biologicals were dated when opened in three of three medications carts reviewed. Findings include: On 12/08/24 at 4:23 PM, the A medication cart was observed with Licensed Practical Nurse (LPN) D: a glucose test strips container was not dated when opened. On 12/08/24 at 4:26 PM, the D medication cart was observed with LPN A: A vial of Lantus insulin was open and undated; A vial of Humalog insulin was open and undated; A container of glucose test strips was not dated when opened; and two latanoprost eye droppers were not dated when opened. On 12/09/24 at 9:07 AM, the C medication cart was observed with LPN C: a Humalog insulin vial was not dated when opened; three artificial tears eye dropper vials were not dated when opened; and the glucose test strips container was not dated when opened. On 12/10/24 at 11:52 AM, during and interview with the Director of Nursing (DON), the DON reported glucose test strips and insulin vials should be dated when opened and glucose strips were good for thirty days once opened. A review of the facility policy titled, Interdisciplinary Team (IDT) Risk Review Meeting dated 01/02/24 revealed, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. A review of the prescriber information for Lantus revealed vial storage guidelines, .In-use (opened) . 10 mL(milliliter) multiple-dose vial 28 days refrigerated or room temperature . A review of the prescriber information for Humalog revealed vial storage guidelines, .In-use (opened) .10 mL multiple-dose vial . room temperature 31 days . A review of the prescriber information for latanoprost revealed storage guidelines, .Once a bottle is opened for use, it may be stored at room temperature for 6 weeks .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to ensure food was served in a palatable (tasty), presentable manner for three Residents (R39, R45, and R246) of four residents reviewed for nutrition. Findings include: On 12/08/24 at 9:22 a.m., R246 stated they were a newer resident to the facility, admitted on [DATE] for rehabilitation. R246 reported the food did not taste good, and there was little variety. R246 explained the alternates also did not taste good. R246 clarified food was their main concern, as they could barely eat their meals which was upsetting to them. R246 appeared thin in stature and was seated in a manual wheelchair. On 12/08/24 at 10:05 a.m., R45 stated, The food is horrible, and the eggs taste like they are powdered. When asked about alternatives available, R45 reported, The alternates taste horrible, and clarified the bread was old and hard when sandwiches were requested. R45 reported they felt frustrated by this and had reported their concerns to staff. On 12/08/24 at 10:09 a.m., R39 stated, The food is terrible. I don't eat it. I don't like the food here .The grits are bad, and you can pull it out of the bowl with a fork .A lot of times the French toast is cold. Presentation is everything. Some things (food) are looking like they just throw it on the plate .Sometimes the meat tastes old, and they take a teaspoon of gravy and put it in the middle of the meat. R39 explained they would not eat the lunch today, which was chicken pot pie. R39 stated the chicken pot pie on the menu was canned vegetables with biscuits mashed with gravy and tasted terrible. R39 reported when they had a pot pie, they expected it to be in a pie, not served in a bowl. The hot cereal served for breakfast on 12/09/24 was tested and found to to have a more solid form so the entire contents of the bowl could be lifted with a fork. On 12/09/24 at 12:52 p.m., R39 was observed eating chili from a plastic container in their bed, as they were not eating the pot pie. R39 clarified they would eat the food from the facility if it tasted good. On 12/09/24 at 1:00 p.m., R45 was lunch meal. R45 reported they had the chicken pot pie, and stated, It was horrible and tasted like sh***. R45 spoke with an elevated voice and reported this upset them. Review of R45's Minimum Data Set (MDS) assessment, dated 9/16/24, revealed R45 entered the facility on 8/31/22, and was able to feed themselves with set-up. The BIMS (brief interview for mental status) assessment revealed a score of 14/15, which showed R45 was cognitively intact. On 12/09/24 at 1:05 p.m., Certified Nurse Aide (CNA) G was asked about the food served to residents. CNA G stated, 'It's not like home. A lot of families are bringing food in (for the residents). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 9:35 a.m., a kitchen staff, [NAME] H, was asked about the scrambled eggs served at the facility. [NAME] H returned with a liquid egg product in a quarter gallon cardboard container. [NAME] H reported they tasted like scrambled eggs when cooked, however they had heard residents complain they tasted like powdered eggs. [NAME] H reported scrambled eggs were served separately or in combination with cheese or vegetables about twice a week and other times residents received eggs cooked from their shells, such as fried eggs or hard-boiled eggs. On 12/10/24 at 9:37 a.m., a breakfast tray was taste tested , the cheese scrambled eggs and a red beverage were tasted; the scrambled eggs had considerable cheese in them, so the taste was unable to be fully distinguish between the eggs verses the cheese. The drink tasted like a red sugar drink, and was not a juice, but a watered-down sweet cherry tasting beverage. On 12/10/24 at 2:12 p.m., Dietary Manager (DM) I was interviewed with the District manager, Staff J. Surveyor asked both regarding the chicken pot pie served for lunch on 12/09/24, and the taste and presentation concerns. Both explained the chicken pot pies were made in a large bowl, with biscuits baked on top of the bowl. DM I reported they had a new supplier, and in the past, they had chicken pot pies served whole as pies to residents from another supplier, so the residents may have recalled this. Staff J confirmed the liquid egg mix was served as scrambled eggs. DM I with Staff J acknowledged the residents' concerns. DM I stated, I do acknowledge the concerns. The cooks will benefit from some education and in-services. On 12/10/24 at approximately 3:45 p.m., during an interview with the Nursing Home Administrator (NHA) with the Director of Nursing (DON) present regarding the residents' food concerns, they reported these concerns would be best addressed by the dietary management staff. Review of the policy, Nutritional Services, dated 1/02/24, did not address food palatability, resident preferences, or presentation of food.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to ensure non-allergenic food was provided for one Resident (R13) of one reviewed for food preferences. Findings include: On 12/10/24 at approximately 1:05 p.m., R13 reported they were served Shrimp [NAME] last night for dinner, which they were allergic to. R13 reported they believed it was Chicken [NAME] when the dinner was served. R13 reported they were chewing the meat and realized it was shrimp and spit it out immediately and asked a Certified Nurse Assistant (CNA) to call their nurse. R13 reported an aide was with them, CNA R, and their nurse, Licensed Practical Nurse (LPN) S, who gave them Benadryl (an antihistamine medication for an allergic reaction). R13 reported they had a reaction when their mouth and tongue felt tingling. Review of R13's meal ticket, on 12/10/24 at 1:10 p.m., which was on their lunch meal tray, revealed, (R13) . Allergies: .Seafood . in large, bold print, at the top of their meal ticket. Review of the facility menu showed the dinner entree for Monday's dinner, on 12/09/24, was, Shrimp [NAME] ., which was later confirmed by kitchen staff. Review of R13's Minimum Data Set (MDS) assessment, dated 9/24/24, revealed R13 was admitted to the facility on [DATE]. R 13 was able to feed herself with set up. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R13 was cognitively intact. Further review of R13's medical record, including progress notes, assessments, orders, and medications, showed no notation of the allergice reaction incident. On 12/10/24 at approximately 1:15 p.m., the Assistant Director of Nursing (ADON), Registered Nurse (RN) Q, were asked if they were aware of the allergice reaction incident. RN Q reported they were not aware, and confirmed the facility was not aware this occurred. On 12/10/24 at 1:26 p.m., RN Q confirmed R13 described the incident to them. RN Q reported R13 confirmed they had a tingling tongue when they took the bite of the shrimp, from dinner on 12/09/24, which resolved once they spit the food out and received allergy medication. RN Q confirmed R13's seafood allergy. They reported the medical record showed the reaction to seafood was unknown and questioned how this happened in their dietary department. On 12/10/24 at approximately 1:35 p.m., RN Q called LPN S, who did not answer the phone or call back during the interview. Review of the nursing schedule dated 12/10/24 confirmed Certified Nurse Aide (CNA) R worked with R13 on their hall the evening shift on 12/09/24. Review of the medical record with RN Q confirmed there was no notation of this incident, including in progress notes, assessments, orders, or otherwise. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's allergy page in the medical record, accessed 12/10/24, revealed a seafood allergy, with a severity of mild, dated 2/21/2023. On 12/10/24 at approximately 1:41 p.m., CNA R was called and asked about the incident. CNA R described R13 had some pasta for dinner and thought it was chicken but it was shrimp. and knew they were allergic to shrimp. CNA R reported they notified LPN S immediately, who administered R13 medication. On 12/10/24 at approximately 1:50 p.m., RN Q reported this was concerning and planned to immediately follow-up with the DON (Director of Nursing). On 12/10/24 at 2:12 p.m., the kitchen manager, Dietary Manager (DM) I, was interviewed with the district kitchen manager, Staff J. Both reported they had been notified of the incident. DM I confirmed R13's seafood allergy stating it was, clearly designated on their meal ticket. DM I explained it was the responsibility of both the cook and the dietary staff to read the meal ticket and ensure the food was served per the designation. On 12/10/24 at 2:49 p.m., a phone call was placed to LPN S. No call was returned by the end of the survey to this Surveyor. On 12/10/24 at 3:26 p.m., the Nursing Home Administrator (NHA) was interviewed about the incident with the Director of Nursing (DON). Both confirmed the incident occurred, and they understood R13 had a reaction with their tongue tingling. Review of the policy, Nutritional Management, dated 1/2024, revealed, .Food allergies/intolerances will be identified and confirmed to be notated on the tray card .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 This citation pertains to Intake MI00148803. On 12/08/24 between 8:40 AM-9:15 AM, during an initial tour of the kitchen, the following items were observed: In the walk-in cooler, there was a pan of soup dated 11/26-12/3, an opened undated bag of breaded chicken, an undated bag of whole ham, an undated bag of sliced ham, an opened undated package of hot dogs, an undated pan of tomato sauce, a crate of fat free half pints of milk dated 12/7. In the Traulsen reach-in cooler, there was an opened undated 1 gallon container of Italian dressing, a 1 gallon container of sweet and sour sauce dated 9/13/24-10/13/24, a 1 gallon opened, undated container of BBQ sauce. On 12/8/24 at 12:05 PM, when queried about the opened, undated items, Dietary Manager I provided no explanation. According to the 2017 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. In the dish machine room, there were swarms of gnats observed at the soiled side of the dish machine. Underneath the soiled side sink basin, there was a plate cover on the ground, filled with standing water. There was missing grout in between the floor tiles, with standing water in the wells. On 12/8/24 at 12:10 PM, when queried about the gnats in the kitchen, Dietary Manager I stated a pest control company does come and treat the drains, but did not provide an explanation for the standing, stagnant water on the floor underneath the dish machine. According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: 1. (A) Routinely inspecting incoming shipments of FOOD and supplies; 2. (B) Routinely inspecting the PREMISES for evidence of pests; 3. (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; and 4. (D) Eliminating harborage conditions. In the Motak milk cooler, there was spilled milk pooled at the bottom underneath the milk crates. (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 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. In the resident refrigerator, there was an undated bag with chicken, greens, and mac and cheese, and an undated bag with a whole rotisserie chicken. Review of the facility's policy Food Brought in by Family or Visitors dated 12/12/2023 noted: f. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with resident's name, the item and the use by date.

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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** 50223 This citation has two deficient practice statments. Deficient practice #1. Based on observation, interview, and record review, the facility failed to implement transmission based precautions (TBP) for one resident (R346) out of one reviewed for infection control practices. Findings include: On 12/8/24 at 9:37 AM R346 was observed lying in bed. A sign was observed on R346's door revealed the following: CONTACT PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. R346 explained the sign is there because they have an infection in their dialysis access site. A review of R346's medical record revealed they were admitted to the facility on [DATE] with the following diagnosis: Acute and Chronic respiratory failure with hypoxia (low oxygen level); candidiasis, unspecified. A review of R346's Brief Interview for Mental Status revealed a score of 15 indicating intact cognition. A review of R346's face sheet revealed an alert as follows: Special instructions: .I have colonized candidiasis auris and you must wear PPE with me! A review of R346's progress note dated 11/27/24 revealed the following: Writer just had communication with (name of staff member) from (name of department of health and human services) . regarding the resident's current status with candidiasis auris. The department will be keeping a follow up on the resident while (they) remain here at the facility. (they) are currently on dialysis and they have been informed of (their) status and recommendation to run (them) separate from other residents and cleaning technique. Writer informed therapy and respiratory for any interactions to maintain precautions . On 12/9/24 at 9:48 AM, R346 was observed in dialysis seated in a chair between two other residents who were also receiving dialysis. The dialysis staff member explained they wear PPE (personal protective equipment) when they dialyze R346 due to (their) infection. On 12/09/24 at 09:50 AM, Respiratory Therapist (RT V) was observed in R346's room providing care. RT V was observed wearing gloves but no gown. RT V was observed to exit the room without gloves carrying a plastic bag of trash with one hand and began pushing a cart of respiratory supplies with the other hand. No hand hygiene was performed. RT V was interviewed at this time and explained they did not know if R346 was on transmission based precautions and confirmed they should perform hand hygiene after providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 09:55 AM, Certified Nurse Assistant (CNA) X was observed in R346's room without gloves or a gown. CNA X was observed to touch R346's bedding with bare hands, then proceeded to exit R346's room and use hand sanitizer in the hallway. The CNA was interviewed and explained R346 is on enhanced barrier precautions because they have a tracheostomy (surgically created airway). On 12/09/24 at 10:00 AM, Social Worker (SW) T was observed in R346's room. SW T was not wearing gloves or a gown. SW T was observed to hand R346 a pen to sign a form then took the pen back into bare hands and repeated twice, the SW was then observed leaving R346's room and used hand sanitizer in the hallway. On 12/09/24 at 11:27 AM, Nurse Practitioner (NP) L was observed in R346's room. NP L was observed wearing gloves but no gown. NP L was observed to touch R346's legs, then lift R346's bedding. NP L''s sleeve and side of their white coat leaned and brushed against R346's bedding. NP L was observed then to touch R346's dialysis catheter and subseqestly remove their gloves and then reach into their pocket of their white coat. NP L was then observed to leave R346's room without performing hand hygiene and directly entered the room of another unidentified resident with an enhanced barrier precaution sign on their door. NP L was then observed in the unidentified residents room lifting their bedding and touching the resident without gloves then observed to reach into their pocket and brought out a pen and paper. The NP then exited the room holding the pen and paper without performing hand hygiene then entered another unidentified resident's room. ON 12/9/24 at 11:37 AM, NP L was interviewed and explained they did not know if R346 was on transmission-based precautions. On 12/09/24 at 03:46 PM, during an interview the Director of Nursing (DON) explained transmission-based precautions which include contact and airborne precautions are used when a resident has something to protect us from and with enhanced barrier precautions, we are protecting them. The DON reported R346 was on transmission-based precautions for C. AURIS. The DON confirmed any contact with the resident required contact precautions and PPE with gown and gloves. This includes contact with the bed, call light and giving medications. The DON explained the PPE should be put on at the doorway and removed in the room. On 12/10/24 at 12:42 PM, during an interview the DON also, confirmed R346 should be on transmission-based precautions and they should be dialyzed separate from everyone else. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Infection Prevention & Control Program revealed the following: POLICY This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Definitions: Staff includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. PROCEDURE 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.2. All staff are responsible for following all policies and procedures related to the program . 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies. e. Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department.5. 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 guidelines. b. Residents on transmission-based precautions should be placed into a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards. c. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. d. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmissionbased precaution guidelines. e. Residents with tuberculosis are placed on airborne precautions and placed in a special room that is equipped with special air handling and ventilation capacity. If no such room is available, the resident(s) will be discharged to a facility with such capabilities. f. Immunocompromised and myelosuppressed residents shall be placed in a private room if possible and shall not be placed with any resident having an infection or communicable disease. g. Visitors coming to visit a resident who is on transmission-based precautions or quarantine, will be informed by the facility of the potential risk of visiting and precautions necessary when visiting the resident. 32220 Deficient Practice #2: Based on observation, interview and record review the facility failed to ensure the dressing for a peripherally inserted central catheter (PICC) line dressing was changed timely and per physician order for one resident (R25) of one whose PICC line care was reviewed. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 10:33 AM, R25 reported they had received antibiotics for and infection which sent them to the hospital. R25 reported they still had the PICC line in their right upper arm. A observation of the upper arm revealed a transparent dressing had been placed over a white gauze dressing. The insertion point could not be visualized. The dressing was dated for 12/2/24. R25 reported the PICC was to come out but it had not been determined if more antibiotics were needed. On 12/10/24 at 10:36 AM, Licensed Practical Nurse (LPN) E was asked if R25 had a PICC line dressing change and commented they thought the PICC line had been pulled and the night shift nurses are the ones who normally change the dressing. The upper arm of R25 was observed with LPN E and the 12/2 date and gauze dressing were in place as on the day before. R25 reported the line had not been flushed in a number of days. On 12/10/24 at 11:52 PM, the Director of Nursing (DON) was interviewed about the PICC line dressing and reported the PICC line should have been discontinued after the antibiotic was completed and no gauze should have been used. The also reported the dressing should be changed weekly. A review of the record for R25 revealed R25 was admitted into the facility 02/05/2014. Diagnoses included Paraplegia and Diabetes. An order by physicianH dated 10/24/24 documented, PICC/Midline change dressing q (every) seven days . A review of the Medication Administration Record and Treatment Administration Records (TAR) (MAR) for December 2024 revealed, Monitor right upper arm PICC line . was initiated 10/24/24. Eight different nurses had documented monitoring the site since 12/2 through 12/09. The nurses did not document a dressing change. A review of the policy titled, Vascular Access Management dated 04/04/2018 revealed, .Dressing are labeled with the date performed or the date to be changed based on facility policy .Gauze and opaque dressings should not be removed if resident has no clinical signs of infection .Site care and dressing changes . performed at least every five to seven days .