STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235062	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandvue Medical Care Facility	1728 S Peninsula Road East Jordan, MI 49727

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to notify the resident and/or resident representative in writing with the reason for a transfer out of the facility for four Residents (#15, #25, #87, #34) of four residents reviewed for transfer and/or discharge. Findings include: Resident #87 (R87) Review of R87's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia and Parkinson's disease. Review of the facility census report revealed R87 was hospitalized from 3/11/25 - 3/13/25. Review of a progress note dated 3/11/25 at 12:39 PM read, in part: Resident being transported to [acute care hospital] d/t (due to) swelling in LLE (left lower extremity) and thigh . Review of a facility document titled, Notification of Transfer and Bed Hold Authorization, dated 3/11/25, did not reveal the reason for transfer for R87. 41978 Resident #34 (R34) Review of the Minimum Data Set (MDS) assessment, dated 2/28/2025, revealed R34 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury and seizure disorder. Review of R34's EMR revealed the following progress note: 3/5/2025 19:23 Nursing Note . Resident was sent to the hospital for possible sepsis. Running fever, elevated BP (blood pressure) and pulse. Resident was sitting up in bed in pain this evening, all muscles engaged. Skin was red and blotchy. Ambulance was called. ER (emergency room) in [local acute care hospital] was called. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled, Notification of Transfer and Bed Hold Authorization, dated 3/5/2025, revealed the document did not include a reason for R34's transfer out of the facility. 49310 Resident #25 R25 was admitted to the facility on [DATE] with a primary diagnosis of memory deficit following cerebral infarction (stroke). The EMR revealed R25 was transferred to the hospital on the following dates: 1/6/25, 1/10/25, 1/14/25, and 1/19/25. The documents Notification of Transfer and Bed Hold Authorization did not reveal the reason for the transfers to the hospital for R25 on these dates. Resident #15 R15 was admitted to the facility on [DATE]. The primary diagnosis of R15 was acute pulmonary edema (buildup of fluid in the lungs). The EMR revealed R15 was transferred to the hospital on the following dates: 2/12/25, 2/17/25, 2/27/25, and 3/11/25. The documents Notification of Transfer and Bed Hold Authorization did not reveal the reason for the transfers to the hospital for R15 on these dates. The Assistant Director of Nursing (ADON) was interviewed on 3/20/25 at 9:18 AM. The ADON was asked if the facility had written notifications of transfer for residents and resident representatives. The ADON provided bed hold information but did not provide written notifications of transfer. A policy was requested. The ADON and Director of Nursing (DON) were interviewed on 3/20/25 at 9:50 AM. The DON said there were no written notifications of transfer issued to residents or resident representatives. The ADON said the facility had a documented procedure and provided an undated document Notice of Resident Transfer of Discharge Process. The document read, in part: . Notice Requirements Before Transfer/Discharge, the facility must provide written notice to any Resident or Resident Representative . 3. The Social Worker/designee will complete the Notice of Resident Transfer or Discharge and, as soon as is practicable, will mail said notice . When a signed notice is returned, it will then be placed in the Resident's hard chart . The DON was queried regarding the form referenced in the written procedure. The DON provided a blank copy of a form titled Notice of Resident Transfer or Discharge. The form included the necessary written requirements for transfers. The DON was again asked if the forms for written notification of transfers had been completed for the residents who had been transferred to the hospital. The DON reiterated the forms had not been completed. The ADON said the form used to be used but could not explain why the facility had stopped providing written notifications of transfer.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) assessment documentation was accurate for one Resident (#23) of 19 residents reviewed for assessments. This deficient practice resulted in the potential for lack of appropriate care and services. Findings include: Resident #23 (R23) Review of R23's Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on [DATE] with diagnoses including: Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or stroke, hemiplegia (paralysis that affects one side of your body), and dementia. Section P revealed a wander/elopement alarm was used daily. R23 scored a 5 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. During an observation on 3/18/25 at 1:11 p.m., R23 had a [Name Brand] alarm on her left ankle and was seated in a wheelchair while propelling the wheelchair in a secured/locked unit of the facility. During an interview on 3/19/25 at 10:41 a.m., Licensed Practical Nurse (LPN) A reported R23's balance had declined since admission in 2013, and the resident does not walk around the secured unit of the facility anymore. When asked who assesses the use of the alarms for residents, LPN A stated they did not know. During an interview on 3/20/25 at 8:41 a.m., Director of Nursing (DON) reported that the facility fills out risk assessments for residents who need an alarm upon admission, quarterly, and as needed. The DON reviewed the Electronic Medical Record (EMR) for R23 which revealed the last risk assessment was completed on 8/9/24. During an interview on 3/20/25 at 9:12 a.m., Housekeeping Aide B reported R23 does not try to get out of the doors of the locked unit of the facility since [R23] does not walk and is in a wheelchair. During an interview on 3/20/25 at 9:16 a.m., Nursing Neighborhood Assistant C reported R23 does not try to leave out any of the exit doors. During an interview on 3/20/25 at 9:18 a.m., Nursing Neighborhood Assistant D reported R23 watches TV, has snacks during the day, and sleeps a lot, but does not try to leave the locked unit. During an interview on 3/20/25 at 9:26 a.m., Activity Aide/Certified Nursing Assistant (CNA) E stated, I cannot recall the last time I saw [R23] head towards an exit. During an interview on 3/20/25 at 9:29 a.m., CNA F reported R23 used to walk towards the exits seven years ago. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/25 at 9:31 a.m., Registered Nurse (RN) G reported R23 goes to the dining room and propels the wheelchair around the locked unit of the facility but has not tried to leave the locked unit over the past year. During an interview on 3/20/25 at 10:08 a.m., Social Worker H reported that R23 had not tried to leave the locked unit in the past year and the LPN/Care Coordinator will do a risk assessment for the alarm for residents that try to elope. During an interview on 3/20/25 at 10:15 a.m., LPN/Care Coordinator I stated, It had been at least a year since [R23] tried to leave the locked unit .the residents are assessed quarterly and I did not realize I missed the assessment . During an interview on 3/20/25 at 10:29 a.m., the DON acknowledged R23 should be assessed quarterly for the [Name Brand] alarm and R23 had not tried to leave the facility. The DON reported the facility had a policy on the alarm assessment which was requested at the time of this interview. During an interview on 3/20/25 at 10:48 a.m., Registered Nurse/MDS/Assistant Director of Nursing (RN/MDS/ADON) J stated, R23 has not had an elopement incident in over a year .there is no need for [R23] to have the [Name Brand] alarm at this time .R23 should have been assessed quarterly for the [Name Brand] alarm as part of the quarterly MDS assessment . Review of facility policy titled Elopement and Wandering Resident last reviewed 2/5/25, read in part .Alarms are not a replacement for necessary supervision .[Facility name] shall establish and utilize a systematic approach to monitoring and managing residents including identification and assessment .evaluation and analysis of hazards and risks .and monitoring for effectiveness and modifying interventions when necessary . A facility policy regarding the assessment or use of alarms was not provided upon exit of the facility on 2/20/25 at 2:00 p.m.

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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** 41978 Based on observation, interview and record review, the facility failed to update the person-centered care plan for the management and prevention of wounds for one Resident (#53) of one resident reviewed for pressure injuries, resulting in the potential for unmet care needs. Findings include: Resident #53 (R53) Review of the Minimum Data Set (MDS) assessment, dated 12/27/2024, revealed R53 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease and dementia. R53 was rated as having severe cognitive impairment and was dependent on staff for all transfers and bed mobility. On 3/18/2025, at 12:11 p.m., R53 was observed seated in a high-back wheelchair in her room. R53 appeared confused and smiled when asked questions but appeared to be unable to understand the questions being asked and could not participate in an interview. Review of R53's electronic medical record (EMR) revealed the following progress note: 3/18/2025, [9:37 a.m.]. Alert Note. resident with red firm area on left glute. skin intact. resident current with air mattress topper. request for air mattress. open area of coccyx [tailbone] with 99% slough, serosanguinous exudate [drainage]. educated CNA [Certified Nursing Assistant] on the importance of turning schedule. CNA verbalized understanding and confirmed repositioning. An observation of R53's wound care, conducted by Licensed Practical Nurse (LPN) Q, on 3/19/25 at 11:43 a. m., revealed R53 had a wound located on the medial aspect of her right upper buttock. The wound was covered in black eschar (dry dead tissue). Two smaller wounds were noted on R53's left, medial buttock, both wounds were covered in yellow slough (moist, dead tissue). Review of a provider note, dated 3/6/2024 at 12:00 a.m., revealed the following: Assessment and Plans . There is a Kennedy ulcer [unavoidable skin breakdown which occurs as part of the dying process] noted to the coccyx. Review of R53's pressure ulcer risk assessment, dated 3/3/2025, revealed R53 was unable to make frequent or significant changes [in position] independently. During an interview on 3/20/2025 at 9:43 a.m., CNA R was queried as to how care staff were aware of what care needs R53 had. CNA R reported CNA staff refer to the Kardex (bedside care plan report) which is in a binder outside the Resident's room. CNA R reported she floats to all units in the facility and relies on the bedside care plan reports to know what type of assistance residents require. When asked how staff knew how often a resident should be repositioned or weight offloaded, CNA R reported staff would refer to the care plan report for specific information. CNA R stated residents are usually repositioned every two hours when in bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R53's Visual/Bedside Individual Care Service Plan Report, found in a black binder located in a pocket on the wall outside the Resident's room, revealed the following: Skin Care/Pressure Relief: Calmoseptine (type of medicated ointment) to open pressure area and protective ointment to peri areas of incontinence . Bed Mobility: dependent for significant position changes. Wedges for repositioning support/pressure relief. It was noted the bedside care plan report contained no information related to how often R53 should be repositioned or how often weight should be offloaded from R53's wound. A review of R53's comprehensive care plan, revealed the following: Pressure/Skin Injury: The resident has a history of pressure ulcer development [related to] immobility, age related fragility, anti-platelet therapy. Date Initiated:4/08/2024 . Interventions: Encourage repositioning throughout the day and night if you see that the resident has not done so herself. Date Initiated: 4/09/2024. It was noted the care plan did not include information on how often R53 should be repositioned nor was the care plan updated to reflect R53's dependence on staff for position changes. During an interview on 3/20/2025 at 9:36 a.m., Nursing Care Coordinator and Registered Nurse (RN) S reviewed R53's current care plan and confirmed R53's care plan was not updated to reflect the presence of the Kennedy ulcer and did not include an intervention to turn and reposition R53 at least every two hours for comfort and to attempt to prevent new wounds from forming. RN S confirmed R53 should be repositioned at least every two hours. Review of the facility policy titled, Baseline Care Planning and Resident Centered Care Planning, revised 2/19/2025, revealed the following: The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0684 Level of Harm - 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** 49310 Based on interview and record review, the facility failed to follow physician orders for readmission to the facility in two Residents (#25 and #15) of three residents reviewed for quality of care following hospitalization . This deficient practice resulted in rehospitalization for excessive clotting times following a history of GI bleed for R25 and rehospitalization with worsening urosepsis for R15. Findings include: Resident #25 (R25) A nursing progress note in the Electronic Medical Record (EMR) dated [DATE] at 3:06 PM documented R25 had hypoxia (low oxygen level), a gray color to the skin, increased confusion, and a blood pressure of , d+[DATE]. The physician was notified and R25 was transferred to the Emergency Department (ED) and admitted to the hospital. A hospital discharge summary dated [DATE] documented R25 with an INR result of 12.9 upon arrival to the ED on [DATE]. The discharge summary recapped concerns identified in the hospital including acute blood loss anemia, acute GI (gastrointestinal) bleeding, and supratherapeutic (exceeding therapeutic limits) INR. The discharge summary reflected R25 required blood transfusions while hospitalized . A GI scope was performed and identified evidence of upper GI bleeding with blood clots within the stomach. R25 was admitted to the facility on [DATE] with a primary diagnosis of memory deficit following cerebral infarction (stroke). The EMR revealed R25 had a prosthetic heart valve and was prescribed the anticoagulant warfarin (a blood thinning medication that can result in excessive bleeding and death if given in excessive doses). A care plan Focus for R25 documented, in part: BLEEDING [sic]: At risk for uncontrolled bleeding from use of Coumadin [warfarin] therapy related to aortic valve replacement . The care planned goal was to maintain the INR (International Normalized Ratio, a blood test for warfarin that measures blood clotting times) between 2.5 - 3.5. R25 returned to the facility on [DATE] with an INR of 1.26. Physician's orders included tight INR control and resume warfarin on [DATE]. The Medication Administration Record (MAR) documented R25 received warfarin 3 milligrams (mg) on [DATE] despite the physician's order from the hospital to resume the medication on [DATE]. A nursing progress note in the EMR on [DATE] at 9:04 AM documented R25's provider was notified to discuss R25 experiencing a change in condition overnight. The progress note reflected R25 had a systolic blood pressure in the 80's, hypoxia, lethargy, and crackles throughout the lung fields. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R25 was transferred back to the ED on [DATE] where a laboratory draw identified an INR of 5.1. A hospital discharge summary dated [DATE] documented, in part: . I spoke with nursing at [name of facility redacted], patient has reportedly only received a single 2.5 mg dose of warfarin on [DATE] that is increased his INR from 1.26 on [DATE] to 5.61 today .warfarin has been held, suggest a recheck of INR tomorrow . continue to hold warfarin therapy until INR between 2 and 3, recommend reducing dosage on reinitiation, close monitoring every other day . R25 returned to the facility on [DATE]. The MAR documented warfarin was administered to R25 on [DATE] and [DATE] despite the physician's order to withhold the medication. A nursing progress note on [DATE] at 3:55 PM documented the provider was notified and made aware the warfarin was not placed on hold when R25 returned from the hospital. The provider again ordered the medication to be withheld until laboratory testing of INR was returned. A laboratory report dated as obtained on [DATE] and dated as reported to the facility on [DATE], documented INR results > (greater than) 10. A provider's note in the EMR dated [DATE] at 12:00 AM documented, in part: . [R25] presents for evaluation due to elevated INR. Preliminary result from yesterday's draw is INR > 10 .CCC [Clinical Care Coordinator] discovered that patient's Coumadin was not held since readmission to the facility. Discussed with CCC option to perform reversal using available Vit [vitamin] K in the facility and to closely monitor INR by checking daily or every other day. However, given patient's very recent hospitalization for suspected GI bleed leading to anemia and acute hypoxia, CCC is concerned that patient is at higher risk for bleeding. Facility has limited ability to check INRs in a timely manner . R25 was transferred back to the ED on [DATE] for a supratherapeutic INR. The CCC (Registered Nurse (RN) N) and Assistant Director of Nursing (ADON) were interviewed on [DATE] at 10:12 AM. RN N said warfarin is monitored through INRs to ensure the medication is within therapeutic parameters for a resident. RN N confirmed the therapeutic range for R25 was an INR between 2.5 - 3.5. The ADON said there was also an order to monitor for bleeding each shift, and the order to monitor for the side effects of bleeding should be on the TAR (Treatment Administration Record) for nurses to document each shift. The medical record for R25 was reviewed with RN N. No order was found to monitor R25 for bleeding, nor did the TAR contain an entry for nurses to document monitoring for the side effect of bleeding. RN N was asked about the supratherapeutic INRs and subsequent hospitalization s for R25 in [DATE]. RN N said the INRs for R25 got wonky in January. RN N said, This mess might have been prevented with a point of care INR machine. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	RN N expressed challenges with the contracted laboratory provider, including the lab not open or available when needed, specimen collections were required to be obtained before 4:00 PM, and there was no availability to obtain laboratory draws on weekends. RN N explained the laboratory courier picks up labs at 4:00 PM on weekdays only, then the specimens were taken to (city approximately 50 miles from facility) to then be shipped to out of state within the country to conduct the testing. RN N asserted, I don't know how that's feasible! I've had heated [NAME] about this lab. RN N said the facility is not notified timely of laboratory results. RN N said laboratory results are not known until the next day or several days after laboratory specimens were obtained. RN N was asked why warfarin continued being administered to R25 when the discharge summary from the hospital dated [DATE] directed the medication to be withheld. RN N did not provide an explanation. The Director of Nursing (DON) was interviewed on [DATE] at 12:42 PM. The DON was asked why the warfarin was administered despite an order to withhold the medication. The DON said she suspected the facility did not receive the discharge summary dated [DATE] or the instructions from the hospital until [DATE] because that was the date the discharge summary was entered into R25's EMR. The DON said the provider did not enter the order to hold the warfarin in the EMR. The DON explained the facility practice was for providers to enter their own orders in the EMRs. The Medical Director (MD) was interviewed on [DATE] at 12:50 PM. The MD said he would not have been concerned about INR draws being obtained after being identified as supratherapeutic if the resident was not receiving warfarin. The MD said he was not notified until today ([DATE]) that R25 received warfarin when it should have been withheld. Resident #15 (R15) R15 was admitted to the facility on [DATE] with a primary diagnosis of acute pulmonary edema (buildup of fluid in the lungs). A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R15 was cognitively intact. The MDS documented R15 was independent with dressing, personal hygiene, bed mobility, transfers, and ambulation. No history of genitourinary surgeries or concerns were reflected in the MDS. A nursing progress note in the EMR dated [DATE] at 9:00 AM documented the provider was notified of R15 experiencing a change of condition including vaginal itching, burning with urination, increased frequency of urination, constant dribbling of urine, and a change in the appearance of the urine. The appearance of the urine was documented as thick, creamy, with an abnormal color. The note reflected R15 was lethargic, weak, non-ambulatory, and required lift equipment for transfers. The note documented a concern for infection. A nursing progress note in the EMR dated [DATE] at 12:00 PM documented the provider was notified of a preliminary urinalysis results showing bacterial growth and concern for possible UTI (urinary tract infection). The provider prescribed antibiotics. A progress note dated [DATE] at 10:15 AM documented R15 began vomiting and experienced hypotension (low blood pressure), rapid heart rate and respirations, and severe burning with urination. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R15 was sent to the ED on [DATE] and was admitted to the hospital for UTI (Urinary Tract Infection), sepsis (a life-threatening complication resulting from an infection), acute kidney injury, and others. The urine test in the hospital showed Lactobacillus (a type of bacteria). R15 was discharged back to the facility on [DATE] with orders to administer amoxicillin (an antibiotic) 875 mg twice daily. Review of the MAR revealed the amoxicillin was not administered to R15. The amoxicillin order was not reflected on the February 2025 MAR. A nursing progress note dated [DATE] at 8:45 AM documented the provider was notified R15 had not received any antibiotics since returning from the hospital after the inpatient stay for urosepsis. The note revealed an on-call provider was contacted on [DATE] and [DATE] but the on-call provider was unable to access R15's chart or receive the fax of the hospital discharge. The nursing progress note of [DATE] at 8:45 AM documented, in part: .Today I'm concerned [R15] is becoming septic again AEB [As Evidenced By]: lethargic, confused with inability to answer questions . rhonchus lung sounds .RR [respiratory rate] 40, HR [heart rate] 100 .indwelling foley catheter shows blood clots, sediment, and milky/pink colored urine .Concerns for rebound sepsis vs. heart failure fluid overload or both The note documented the provider's response was to send R15 to the ED. R15 was transferred back to the ED and admitted to the hospital on [DATE] for Urosepsis. Review of a nursing progress note dated [DATE] at 4:35 PM revealed the provider who discharged R15 from the hospital on [DATE] contacted the facility regarding R15 not receiving amoxicillin as prescribed. The note documented, in part: .I let [hospital provider] know we were not able to get any further antibiotic recommendations from our telehealth on call providers Saturday [[DATE]] and Sunday [[DATE]]. He stated that in the future if there are problems like this to please contact the hospitalist on call at the hospital . R15 returned to the facility on [DATE] and was subsequently placed on comfort measures. R15 expired [DATE]. The DON and MD were interviewed on [DATE] at 1:00 PM. The DON said R15 returned to the facility with orders for amoxicillin but R15 was allergic to penicillin. The MD said he was not notified of R15 not receiving amoxicillin as prescribed by the hospital provider. The MD said the nurse practitioner was notified on [DATE] and assessed R15. The nurse practitioner ordered R15 sent to the ED. Neither the MD nor DON provided an explanation why the medical director or hospital was not notified when the on-call provider failed to prescribe a different antibiotic when the allergy was identified.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 45123 Based on observation, interview, and record review, the facility failed to properly label medications and dispose of expired or discontinued medications in three medication carts of four medication carts reviewed and one medication room of two medication rooms reviewed for medication storage. Findings include: On 3/18/25 at 12:35 PM, the Valleyvue B medication cart was observed. The medication cart had an insulin pen containing glargine, with an expiration date of 3/9/25 which remained accessible for administration in the medication cart supply. On 3/18/25 at 12:37 PM, an interview was conducted with Registered Nurse (RN) L, who was asked if the insulin pen was still usable. RN L looked at the pen and immediately threw it out replying, The resident does not use it that often. The pen should have not been in the medication cart. On 3/18/25 at 12:51 PM, the Lakevue B medication cart was observed. The medication cart had a box of two auto-injector pens containing epinephrine 0.3 mg (milligrams). The printed expiration date on the box was 1/2025. An insulin pen was also observed with a date written when it was opened on 3/17/25, but no expiration date was observed. On 3/18/25 at 12:53 PM, an interview was conducted with RN M, who was asked what kind of allergy the resident had related to the availability of an emergency pen (epinephrine) and replied, They are allergic to bee pollen, clonazepam (anti-anxiety agent), and honeybee venom. RN M visualized the epinephrine and confirmed the medication was expired. When asked about the insulin pen, RN M said insulin pens are required to reflect the expiration date, so staff are aware when the medication is expired. On 3/18/25 at 3:06 PM, the Lakevue A medication cart was observed, and was found to have an antipsychotic medication haloperidol liquid, with dispensed date of 2/4/25 which contained no expiration date after opened. The medication cart also had an insulin lispro pen with opened date of 3/15/25 and was labeled to be expired on 4/26/25. The insulin pen was identified as having an incorrect expiration date and should have been labeled to expire on 4/12/25, a 28-day period, not a 42-day period. The medication cart also contained two other insulin pens observed to be dated incorrectly. On 3/18/25 at 3:20 PM, an interview was conducted with RN L, who was asked if the insulin pens were dated correctly for expiration dates and replied, No. Apparently someone does not know how to do math. On 3/18/25 at 1:16 PM, a review of the narcotic book for Valleyvue B was conducted and was found to have a discontinued controlled substance medication remaining in the active medication supply. The medication was Lorazepam 0.5 mg, with dispensed date of 1/24/25 and physician order to be discontinued on 2/7/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/25 at 2:55 PM, an interview was conducted with RN L, who was asked when discontinued medications in the medication cart should destroyed. RN L replied, As soon as possible. That same resident had morphine as well and that was discontinued and destroyed. I really don't know why that medication (Ativan 0.5 mg) is still in the medication cart. On 3/18/25 at 3:21 PM, an observation was made of the medication storage room located on Lakevue. A bottle of geri-tussin (cough syrup) 16 ounces with expiration date of 10/24 was observed in the medication room supply. RN M had a surprised look of her face when this Surveyor handed her the expired medication. On 3/19/25 at 9:44 AM, an interview was conducted with the Director of Nursing (DON) who was made aware of the medication storage findings. The DON replied, Expired medications are to be thrown out if they are expired. Narcotics that have been discontinued are to be destroyed with management as soon as possible, within a few days, and we are here Monday through Friday. Insulin pens are to be correctly dated after being opened with an expiration date. The DON confirmed medication carts and medication storage rooms are audited weekly by nursing and was not sure why expired medications were left in the active medication supply areas. The DON stated, Obviously the staff need to be re-educated on the process because things are being missed and overlooked. Review of policy titled, Unused Medications, Disposal of, dated 10/16/24, read in part, Policy: It is the policy of (facility name) that all unused medications will be disposed of safely and legally .DEA (Drug Enforcement Administration) controlled substances: 1. DEA controlled substance medication (narcotic) cannot be returned to the pharmacy .2. Two of the following personnel types must be present to witness destruction: a. Director of Nursing b. RN Care Coordinator c. Neighborhood Nurse d. Registered Pharmacist e. Certified Pharmacy Technician f. RN or LPN (Licensed Practical Nurse) Consultant Nurse employed by the pharmacy 3. Controlled medications are destroyed via the Drug Buster Drug Disposal System . Review of policy titled, Labeling of Medications and Biologicals, dated 10/23/24, read in part, Policy: It is the policy of (facility name) to ensure all medications and biologicals used in the facility will be labeled in accordance with current guidance . Review of facility document titled, Insulin Storage Recommendations, dated 2022, read in part, . Cartridges/Pens .insulin lispro and insulin glargine pen, opened up to 28 days . Review of facility document titled, Medication Storage and Labeling, undated, read in part, .Medication Carts . All opened medications are labeled with an open date and an expiration date. The expiration date may be the circled manufacturer expiration .Insulin Pens .Verify open date and expiration date . Review of facility document titled, Medication Storage Audit, undated, read in part, Drugs and biologicals are correctly/securely stored .7. DC'd (discontinued) and/or expired meds removed .11. Medications have expiration dates . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy titled, Medication Storage, dated 10/30/24, read in part, Policy: It is the policy of (facility name) to ensure all medications will be stored in the medication cart and/or medication rooms according to the manufacturer's recommendations and regulatory guidelines and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 F770 Grandvue Based on interview and record review, the facility failed to ensure laboratory services were provided to meet the needs of one Resident (#25) of one resident reviewed for laboratory services. Findings include: Resident #25 A review of the Electronic Medical Record (EMR) for R25 revealed admission to the facility on [DATE] with a primary diagnosis of memory deficit following cerebral infarction (stroke). R25 had a prosthetic heart valve and was prescribed the anticoagulant warfarin (a blood thinning medication that can result in excessive bleeding and death if given in excessive doses). A review of the Medscape information on Warfarin revealed the safety and efficacy is dependent on maintaining an INR (International Normalized Ratio, a blood test that measures blood clotting) within a specified target range. A review of the EMR revealed R25 was transferred to the hospital on [DATE], [DATE], and [DATE] where R25 was determined to have supratherapeutic (exceeding therapeutic limits) INR results. When R25 was transferred back to the facility after a hospitalization on [DATE], the hospital discharge instructions directed, in part: Check INR every 24 hours to monitor downward trend . A nursing progress note dated [DATE] at 1:30 PM documented the provider was made aware of the hospital specifying daily INRs. The note indicated concern the facility did not have lab availability on Saturdays or Sundays. The response from the provider was to allow R25 to return to the facility with INRs to be drawn on Wednesday ([DATE]), Friday ([DATE]), and Monday ([DATE]) and to hold warfarin through Wednesday [DATE]. Review of the EMR demonstrated the laboratory draw was obtained on [DATE]. The laboratory report read Test not performed. Specimen submitted in expired/outdated collection device. The laboratory report documented the specimen was obtained on [DATE] but not reported until [DATE]. R25 was transferred to the hospital Emergency Department on [DATE] and the hospital obtained an INR. The EMR of R25 revealed laboratory results were not reported for at least 24 hours after laboratory specimens were collected. The results of an INR collected on [DATE] was reported to the facility on [DATE]. A laboratory report containing critical results was obtained on [DATE] and reported to the facility [DATE]. The results of an INR collected on [DATE] was reported to the facility on [DATE]. A laboratory result collected on [DATE] was reported on [DATE]. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Clinical Care Coordinator (Registered Nurse (RN) N) was interviewed on [DATE] at 10:12 AM. RN N expressed challenges with the facility's provider of laboratory services. RN N said the lab was not open or available when needed and said the laboratory was closed on weekends, so they were unable to obtain laboratory specimens on weekends. RN N said the laboratory courier required all specimens to be ready for pick-up by 4:00 PM Monday through Friday so evening lab draws were an impossibility. RN N explained the lab specimens were picked up at 4:00 PM and taken to (the name of a city approximately 50 miles from the facility) to then be shipped to another state in the USA to conduct the testing. RN N asserted, I don't know how that's feasible! I've had heated [NAME] about this lab. RN N confirmed the facility is not notified of lab results until the next day or several days later. The Assistant Director of Nursing (ADON) was interviewed on [DATE] at 9:23 AM. The ADON said the facility obtained a contract with a new laboratory services provider about a year ago. The ADON said the facility experienced many issues and concerns with the new laboratory provider, and management was aware of the nurses' concerns with the new provider of laboratory services. The policy titled Laboratory and Ancillary Medical Services dated as reviewed [DATE] read, in part: . It is the policy of [name of facility redacted] to provide laboratory and ancillary medical services . Laboratory services will be provided by a contracted laboratory. Emergency and after hours services will be provided .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49735 Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee met at least once per quarter with the required committee members resulting in the potential for quality-of-care concerns for all 93 residents in the facility. Findings include: A review of the facility QAPI sign in sheets on 3/30/25 at 11:00 a.m., revealed the following: Meetings were held on4/17/24, 5/15/24, 6/19/24, 7/17/24, 10/16/24, 11/20/24, 12/18/24, 1/15/25, and 2/19/25. The meeting held on 7/17/24: The Medical Director or designee did not attend. The facility did not have a QAPI meeting in August 2024 or September 2024. The Medical Director or designee, who is a required committee member, did not attend the QAPI meeting during the quarter of July, August, and September. During an interview on 3/20/25 at 11:26 a.m., the Director of Nursing (DON) reported she was unaware the Medical Director did not attend the meeting and offered to provide proof the Medical Director did attend via zoom for the 7/17/24 meeting. The missing attendance record was not provided by survey exit on 3/20/25 at 2:00 p.m.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 F883 Grandvue Based on interview and record review, the facility failed to administer recommended pneumococcal vaccinations or document the clinical reasons for withholding the pneumococcal vaccinations in three Residents (#36, #75, and #15) of five residents reviewed for immunizations. Findings include: Resident #36 (R36) A nurse progress notes in the EMR (Electronic Medical Record) on 12/3/24 documented R36 was confused with no verbal response to questioning. R36 had a temperature of 101.4 degrees Fahrenheit and a heart rate of 122 beats per minute. The on-call provider was notified and ordered R36 transferred to the Emergency Department (ED) for evaluation. R36 was subsequently admitted to the hospital with Pneumonia. A review of the EMR for R36 revealed an [AGE] year-old resident admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 indicating R36 was cognitively intact on admission. The MDS documented the pneumococcal vaccinations for R36 were up to date. A vaccination consent form signed by R36 on 6/5/24 documented R36 wished to receive the pneumococcal vaccines indicated per CDC (Centers for Disease Control) guidelines, including a PCV20 (type of pneumococcal vaccine). An immunization report for R36 was reviewed on 3/20/25 and revealed R36 received the PCV13 vaccination on 5/18/15 and a PPSV23 vaccination on 10/31/07. No further pneumococcal vaccinations were administered to R36, including the PCV20 recommended by the CDC and requested on the consent form signed by R36. There was no physician's documentation in the Electronic Medical Record (EMR) for R36 indicating the physician addressed the request for administration of PCV20 for R36. Resident #75 (R75) R75 was an [AGE] year-old resident admitted to the facility on [DATE]. A vaccination consent form was signed by the resident representative on 8/8/23 requesting vaccinations if indicated per CDC guidelines, including the PCV20. An admission MDS dated [DATE] documented the pneumococcal vaccinations for R75 were up to date. An immunization report for R75 was reviewed on 3/20/25 and revealed R75 received PCV13 on 10/5/16 and PPSV23 on 6/1/18. No further pneumococcal vaccinations had were administered to R75, including the PCV20 recommended by the CDC and as requested on the consent signed by the resident representative of R75. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR of R75 did not contain physician documentation indicating the physician had considered the PCV20 for R75. No documentation by the physician could be found that the physician had discussed the PCV20 with the resident representative of R75. Resident #15 (R15) R15 was a [AGE] year-old resident admitted to the facility on [DATE]. An MDS assessment dated [DATE] documented a BIMS of 14 indicating R15 was cognitively intact. The MDS documented the pneumococcal vaccination for R15 was up to date. A vaccination consent form was signed by R15 on 5/8/24 requesting to receive vaccinations if indicated per CDC guidelines, including the PCV20. An immunization report for R15 was reviewed on 3/20/25 and revealed R15 received the PCV13 on 12/11/15 and the PPSV23 on 10/6/17. No further pneumococcal vaccinations had been administered to R15, including the PCV20 recommended by the CDC and requested by R15 on the consent. There was no physician's documentation in the Electronic Medical Record (EMR) of R15 indicating the physician addressed the request for administration of PCV20 for R15. The Infection Preventionist (IP) was interviewed on 3/20/25 at approximately 11:00 AM. The IP confirmed R36, R75, and R15 did not receive the PCV20 in accordance with their wishes as documented on the vaccine consent forms. The IP was asked if there was any documentation that the vaccinations had been considered for administration. The IP said it was up to the provider to consider the vaccination and to document in the residents' EMR. The IP admitted the provider had not documented consideration of vaccination with PCV20 for R36, R75, or R15. The CDC pneumococcal vaccine recommendations PCV20 or PCV21 Vaccination for Adults 65 or Older (www.cdc.gov/vaccines/hcp/admin/downloads/job-aid-SCDM-pneumococcal-508.pdf) includes, in part: Adults [AGE] years of age or older have the option to receive supplemental PCV20 or PCV21 (not both) if they previously completed the pneumococcal vaccine series with both PCV13 and PPSV23 and meet the following criteria: 1. Previously received one dose of PCV13 (but not PCV15, PCV20, or PCV21) at any age, and 2. Previously received all recommended doses of PPSV23 (including 1 dose of PPSV23 at or after [AGE] years of age) The determination to administer PCV20 or PCV21 is based on a shared clinical decision-making (SCDM) process between a patient and their health care provider . Consider: Increase risk of exposure to PCV20 or PCV21 serotypes [variations of a virus] may occur among people who are living in: Nursing homes or other long-term care facilities . (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled IP Pneumococcal Vaccine (Series) dated as reviewed 6/10/24 documented in part: . It is the policy of [the facility] to offer our residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations . A series of vaccinations will be offered per current CDC guidelines . The resident's medical record must include documentation that indicates at a minimum, the following: a. The resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal .