STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235116	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Woods Nursing & Rehabilitation Center	1684 Vulcan St Muskegon, MI 49442

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 Based on observation, interview and record review, the facility failed to ensure resident choices were honored for one of four residents (Resident #26) reviewed for choices, resulting in feelings of frustration and distress. Findings include: R26 A review of R26's Admission Record, dated 5/16/24, revealed R26 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R26 had multiple diagnoses that included Chronic Obstructive Pulmonary Disease, Weakness, Dysphagia Oropharyngeal Phase, Muscle Weakness, Acquired Absence of Left Leg Above Knee, Diabetes mellitus due to underlying condition with diabetic polyneuropathy, and Phantom Limb Syndrome with Pain. During an interview on 05/14/24 at 11:20 AM, R26 was found in Bed 1 a few doors down from her assigned room. R26 revealed she was in here recouping from yesterday/last night. R26 stated that while she was in the dining room last night (5/13/24) the following incident occurred, my roommate (Name of R7) came into the dining room on her power chair and threatened to hit me, she blew up on me. She was in the dining room yelling, swearing, and shaking her fist at me. To protect me they (staff) took her out of the dining room and had me stay in this room with the door closed last night so she wouldn't see me. During an interview on 05/14/24 at 11:36 AM, R26 further revealed she was moved from her room [ROOM NUMBER]-2 to room [ROOM NUMBER]-1. R26 stated I want to go back to my room today, it's been my room for 3 years. R26 further revealed how important her room is to her and that she is on hospice. During an interview on 05/16/24 at 12:44 PM, NHA revealed she had separated (Name of R26) from her roommate because of an incident in the dining room. That night she (R26) roomed w/ resident next door and was excited because she stated they were having a slumber party. NHA further stated, resident was agreeable to moving rooms then she was not. She is still seeing where she wants to go. She has not made up her mind which room she is going to be in. That's ok we are letting her feel her way. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/24 at 02:01 PM, R26's Responsible Party (RP) AA revealed she had talked with (Name of Social Worker) (SW) Q I told her my mom does not want to move rooms. She wants to go back to her other room. My mom told me she likes to be by the wall. During an interview on 5/15/24 at 2:40 PM, Certified Nurse's Aide (CNA) II stated that she knows R26 want's her room and that it has been her room for about 3 years. CNA II further revealed that (Name of R26) does not like her roommate because she yells and is very mean to her and has expressed that she does not like when she comes back to her room intoxicated and on edge. During a follow-up interview on 05/20/24 at 08:58 AM, R26's RP AA revealed My mom really wants to stay in her room, on Saturday (5/18/24) I went in and saw my mom, she really doesn't want to change rooms. She likes (Name of Roommate) she is staying with; however, she doesn't want to stay in that room because she doesn't want to be in there when the resident passes. Staff told her she could have a worse roommate, then (Name of R7) if she does go back to her room. She has had some bad roommates; she doesn't want somebody worse. Her stuff is still in the other room. RP AA further revealed my mom's previous roommate is hardly in the room. I do not understand why they can't move her. Observation of R26 on 05/20/24 at 9:45 AM found resident to still be in her new room (in a bed away from the wall) with what appeared to be her belongings. R26 stated I really did not want to change rooms, but it's over for now. Resident revealed they (staff) started moving rooms on Saturday/Sunday. When asked why she moved rooms, R26 stated staff told me I could end with a roommate that is worse than her (Name of former Roommate R7). Resident revealed she doesn't want that, and her current roommate is quiet and a pleasant person. Resident states she just feels she has to try and stay as far away from (Name of R7) so they are not in any trouble. R26 expressed she wants to move back into her room as soon as possible.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 This citation pertains to intake MI00144325. Based on interview and record review, the facility failed to notify the responsible party after resident falls for 2 residents (Resident #135 and #58) of 2 residents reviewed for notification of changes, resulting in the physician and family/guardian not being notified of resident changes of condition and the potential for delayed medical intervention and care. Findings include: Resident #135 Review of an Admission Record revealed Resident #135 admitted to the facility on [DATE] with pertinent diagnoses which included metabolic encephalopathy (brain function disturbances caused by chemical imbalance in the blood), unsteadiness on the feet, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #135, with a reference date of 4/23/2024 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #135 was moderately cognitively impaired. Review of Resident #135's Accident Report, dated 4/23/2024 at 7:48 PM, revealed Resident #135 fell to the floor unwitnessed and notification was not made to the physician or family. Review of Resident #135's Interdisciplinary Documentation, dated 4/23/2024 at 7:43 PM, revealed Resident #135 fell to the floor unwitnessed and notification was not made to the physician or family. In an interview on 5/16/2024 at 10:04 AM, Corporate Consultant U reported the physician and family were not notified after Resident #135's fall on 4/23/2024. Corporate Consultant U reported the physician and family should have been notified as Resident #135 had sustained a fall with potential for injury. Review of facility policy/procedure Accident/Incident Report Fall Management, revised June of 2018, revealed .It is the policy of this facility to complete an accident incident report for . falls . Procedure . Notify the family and health care practitioner as soon as possible with assessment findings and document the notification post fall . Review of facility policy/procedure Change in Resident Condition Physician/Family Notification, revised March of 2021, revealed .The health care practitioner will be promptly notified when . The resident is involved in an accident which results in injury and has the potential for requiring practitioner intervention . The resident, or authorized representative will be notified when . The resident is involved in an accident which results in injury and has the potential for requiring practitioner intervention . 31771 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58 (R58) Review of the facility Admission Record reflected R58 admitted to the facility 6/23/22 with diagnoses that included: Alzheimer's Disease, Dementia and Weakness. Review of the Minimum Data Set (MDS) dated [DATE] reflected R58 is severely cognitively impaired but is independent for ambulation. On 513/24 at 2:00 PM, R58 was observed walking in the hall and presented with extensive facial bruising. Review of the Electronic Medical Record (EMR) revealed a Progress Note dated 5/10/24 at 1:49 AM that new bruising was noted to the right side of the forehead of R58. The EMR did not reflect that the Medical Provider or the Responsible Party had been notified. Review of the EMR reflected a Progress Note dated 5/14/24 at 10:38 AM that the Medical Provider and the Responsible Party had been notified three days later, on 5/13/24 of the incident that resulted in the facial bruising. On 5/16/24 at 11:52 AM an interview was conducted with the Director of Nursing (DON) and Corporate Consultant (CC) U in the office of the Nursing Home Administrator (NHA). CC U reported that the nurse did not complete the notifications to the proper parties as is the expectation. CC U acknowledged that the notifications were completed on 5/13/24 and not on 5/10/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 Based on observation, interview, and record review, the facility failed to implement policies and procedures for ensuring the reporting of a resident-to-resident incident for 2 residents' (R7 & R26) out of 13 residents reviewed for abuse and neglect, resulting in the potential for ongoing abuse and/or neglect. Findings include: Review of the facility policy Abuse/Suspected Abuse; Crime Investigation & Reporting last revised February 2023 revealed, It is the policy of this facility to encourage and support all residents, covered individuals, and families, to report any suspected acts involving resident mistreatment, neglect, exploitation, abuse and crimes, misappropriation of resident property or injuries of unknown source. Allegations of abuse and crime are thoroughly investigated and properly reported in accordance with Federal Regulation including the Elder Justice Act. R26 A review of R26's Admission Record, dated 5/16/24, revealed R26 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R26 had multiple diagnoses that included Chronic Obstructive Pulmonary Disease, Weakness, Dysphagia Oropharyngeal Phase, Muscle Weakness, Acquired Absence of Left Leg Above Knee, Diabetes mellitus due to underlying condition with diabetic polyneuropathy, and Phantom Limb Syndrome with Pain. During an interview on 05/14/24 at 11:20 AM, R26 was found in Bed 1 a few doors down from her assigned room. R26 revealed she was in here recouping from yesterday/last night. R26 stated that while she was in the dining room last night (5/13/24) the following incident occurred, my roommate (Name of R7) came into the dining room on her power chair and threatened to hit me, she blew up on me. She was in the dining room yelling, swearing, and shaking her fist at me. To protect me they (staff) took her out of the dining room and had me stay in this room with the door closed last night so she wouldn't see me. Resident further stated, My roommate just yells at me and has threatened to hit me multiple times. I told staff multiple times, but they didn't do anything about it. R26 further revealed she does not like confrontation, so she kept her mouth shut while it was going on. On 5/14/24 at approximately 12:30 PM a review of R26's Electronic Medical Record (EMR) occurred. R26's EMR reflected no incidents were documented between 5/09 - 5/14/24. Records were requested from NHA via email on 5/14/24 at 4:19 PM, for R26 regarding any incident, accident, concern form or grievances from 12/1-5/14/24. Review of an email from the NHA on 5/14/24 at 4:40 PM revealed there are no incident, accident reports for (Name of R26). The email further reflected they were reviewing grievances. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 a concern/grievance was provided in writing concerning R26 and R7 from R26's Responsible Party (RP) AA. Review of the concern email from RP AA on 5/13/24 at 9:25 AM revealed the following: I wanted to let you know something and put in a complaint.We went back to her (R26's) room and seen smoke, I knew she (R7) was vaping. This is so wrong my mom already has health issues, and she does not need this. When I said something to the nurse, she said she would ask her if she would give it to her. We had left the room, I'm not sure if she did or not. Then we told mom's aid and she said oh, she does that all the time. RP AA further wrote, Mom also told me that she is always yelling at her for no reason, and all hours of the night. When she is mad, she makes as much noise as she can so my mom can't sleep. This is so unfair she has to live with someone so disrespectful. I would like to know what you are going to do about this. Review of the facility response to RP AA 5/13/24 9:25 AM reflected Please see attached and *Floors were very dirty on 5/12/24. Looked like they had not been cleaned in a long time. (The allegation about the flooring was not found in the written email provided for review.) Further review of the facility response under How can we address your issues? Ensure that (Name of R26) is content/safe with a roommate. Current roommate is not a good fit for (Name of R26). Do not allow vaping in her room or in the facility. Clean (Name of R26's) room as needed and floors throughout the facility. The response was dated 5/14/24. During an interview on 05/16/24 at 02:01 PM with R26's Responsible Party (RP) AA revealed, I was in to visit my mom on Mother's Day. During the visit I went back to my (Name of R26's) room and I saw smoke. (Name of R7) was vaping in their room so I reported it. My mom (R26) felt she was going to be yelled at and reported to me yesterday (Name of R7) came into the dining room after dinner on Monday and started screaming and yelling at her. My mom was relocated to another room for the night. I think (Name of R7) took it out on my mom because I reported her vaping to the staff. During an interview on 05/16/24 at 12:44 PM NHA revealed I was standing in dining room when it happened. (Name of R7) rolled into the dining room and was not making sense. She was asking (Name of R26) if she was talking smack behind her back. (Name of R26) didn't want to talk and she was not acknowledging her. (Name of R7) was upset and trying to talk so I just separated them. That night we had R26 room w/another resident so we could separate them and let things could cool down. NHA further stated, that (Name of R7) was being very loud and that there was no yelling, shaking of fists, or threats of any kind. NHA did confirm that a note should have been documented in (Name of R26's) record. R7 A review of R7's Admission Record, dated 5/16/24, revealed R7 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R7 had multiple diagnoses that included Post polio Syndrome, Hypothyroidism, Alcohol Abuse, Bipolar Disorder, Major Depressive, Anxiety and Post-Traumatic Stress Disorders. During the survey process R7 was unavailable for interview due to being out on Leave of Absence (LOA). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R7's Electronic Medical Record (EMR) progress notes on 5/13/24 at 21:14 reflected, Resident was noted being aggressive to her roommate. She was talking loudly to her roommate. The roommate was crying when we approached her. (Name of R7) left and went back to her room. Once we finish talking to the roommate, she went back to the dining room and attempted to start arguing again. We were right behind her and defused the situation. (Name of R7) then left the building and returned under the influence of something. She ran into the doorway; she was talking loudly going down the hall. She kept leaving the building and coming back. It was late she was attempting to leave; we knew she was under the influence of something I was concerned so I call the administrator she said if I didn't think she was safe to call the police. She left the facility, and I did call the police. (Name of officer) came in and attempted to speak with her she was still being loud and rude with the officer. He could see where she was in the room pouring drinks on the floor, she went over to her roommates' side and started throwing her stuff around. She continued with this behavior well into the night. She finally calmed down and was quiet in her room [ROOM NUMBER] pm. During an interview on 5/16/24 at 2:40 PM, Certified Nurse's Aide (CNA) II revealed R7 is always coming into the building intoxicated, and she often is yelling at (Name of R26) and is very mean to her. (Name of R26) has expressed she does not like it when (Name of R7) comes back intoxicated and it puts her on edge because she is rude and belligerent. On 05/16/24 at 03:22 PM, DON was asked to provide a copy of the complaint submitted by (Name of Resident 26's) daughter to (Name of Social Services person.) DON and Social Services were asked if the dining room incident was reported, why was it not documented in (Name of R26's) record and it was in (Name of R7's). During a follow-up interview on 05/16/24 at 03:33 PM, NHA stated she was in the dining room when the incident occurred between the residents. NHA stated she had since read the nurses note in R7's chart from 5/13/24 and can see a concern might be alleged when reading it. NHA revealed that a late entry note was being documented in (Name of R26's) record due to investigation of alleged verbal abuse between resident (Name of R26) and her roommate (R7). NHA emphasized they always report everything to the State, and she spends hours doing this. NHA also confirmed that the residents were separated after the dining room incident on 5/13/24. On 5/16/24 at approximately 4:30 PM, NHA revealed she had reported the incident between (Name of R7 & Name of R26.)

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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** 45410 The following citation pertains to intake #MI00143643. Based on interview and record review, the facility failed to revise care plans for 2 residents (Resident #136 and #23) of 3 residents reviewed for care plan revision, resulting in Resident #136's care plan not being revised after a fall and Resident 23's care plan not being revised with the development and worsening of pressure ulcers. Findings include: Resident #136 Review of an Admission Record revealed Resident #136 admitted to the facility on [DATE] with pertinent diagnoses which included heart failure, difficulty walking, and dementia. Review of a Minimum Data Set (MDS) assessment for Resident #136, with a reference date of 4/8/2024 revealed a Staff Assessment for Mental Status score of 3, which indicated Resident #136 was severely cognitively impaired. Review of Resident #136's Incident/Accident Checklist completed by Registered Nurse (RN) BB after Resident #136's fall on 3/15/2024 revealed .new fall care plan intervention in place . Review of a history of Resident #136's increased risk for falls Care Plan interventions revealed no update or change to the care plan after her fall on 3/15/2024. In an interview on 5/15/2024 at 1:02 PM, Corporate Consultant U reviewed Resident #136's care plan history and reported that there were no updates to her care plan after her fall on 3/15/2024. Corporate Consultant U reported there should have been an update to Resident #136's fall care plan after her fall on 3/15/2024. In an interview on 5/15/2024 at 2:10 PM, RN BB reported Resident #136 fell while attempting to get out of bed on 3/15/2023. RN BB reviewed Resident #136's care plan and could not find and post fall interventions. RN BB reported she would have contacted the medical provider and most likely would have placed a new care plan intervention for 15 minute observations in this situation. In an interview on 5/15/2024 at 2:17 PM, RN Unit Manager Z reported nursing staff were to immediately place a new care plan intervention into the resident's chart after a fall. RN Unit Manager Z reported the team would review the incident and care plan later to ensure the revision was appropriate. RN Unit Manager Z was not able to locate any updates to Resident #136's care plan after her fall on 3/15/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/15/2024 at 2:37 PM, the Director of Nursing (DON) reported floor staff are expected to update care plans immediately after falls and the team meets later to review the fall and follow up regarding the appropriateness of the care plan change. The DON reviewed Resident #136's care plan and did not see any care plan updates after her fall on 3/15/2023. 31771 Resident #23 (R23) Review of the Admission Minimum Data Set (MDS) dated [DATE] reflected R23 admitted to the facility 11/15/23 with one stage 2 pressure sore, and was at risk for developing pressure sores. Review of the Skin assessment dated [DATE] reflected moisture associated skin damage (MASD) of the sacral area. Review of the Skin assessment dated [DATE] reflected MASD of the sacral area and the addition of a stage I wound on the left ankle measuring 1 x 0.5 centimeter (cm). Review of the Physician Assistant (PA) documentation dated 1/31/24 revealed an open wound on the right hand. The PA documented that the facility identified this wound on 1/12/24 although the Skin Assessment of 1/17/24 did not include this finding. The MASD of the coccyx had progressed to a stage 2 pressure injury measuring 0.5 x 0.3 x0.1 cm. Lastly, the wound on the left ankle had increased from the size noted above to 1.8 x 1.8 x 0.1. Review of the PA wound documentation dated 2/7/24 included evaluation of the above wounds and reflected the addition of an unstageable right ankle pressure injury. Review of the EMR comprehensive Care Plan and revisions reflected a Focus of (R23) has impaired skin integrity related to fragile aging skin, decreased wound healing secondary to (diabetes mellitus), decreased nutritional intake . and was initiated 11/23/24 and revised on 2/19/24. The Goal is Improvement and prevention of impaired skin and was initiated on 11/23/23 and revised 5/9/24. Neither the Focus nor Goal of the Care Plan reflected revisions were made any time new wounds were identified. Review of the Interventions for this Care Plan Focus are all dated 11/23/23 without any revisions despite the identification and progression of wounds documented on the Skin Assessments and the PA evaluations. The Short Term Care Plan, Wound and Skin for R23 located in a binder and the Nurses Station was reviewed. This Short-Term Care Plan identified the pressure injuries on the left and right ankles. However, this document is dated 4/19/24 which is well after the initial documentation of these areas. No other documentation was provided by the facility prior to survey exit.

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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** 28101 Based on observation, interview and record review the facility failed to provide 1 Resident (R78) with scheduled showers of 3 Residents reviewed for activities of daily living, resulting in R78 having feelings of frustration. Findings included: Review of R78's face sheet revealed the was an [AGE] year-old male that was admitted on [DATE] and had diagnoses that included: difficulty in walking, muscle weakness, and need for assistance with personal care. R78 was his own responsible party. On 5/13/24 at 11:14 AM, R78 was in his room sitting in his wheelchair. R78 was frustrated because he was scheduled for a shower on 5/11/24 and staff said they did not have time to give him a shower, but they would provide a shower on 5/12/24. R78 said he is to get a shower every Wednesday and Saturday evening. R78 again requested a shower on 5/12/24 and again staff said they did not have time to give him a shower. R78 said he had an outside medical appointment this week and really needed a shower before going to that medical appointment. Review of R78's shower task from 4/24/24 to 5/18/24 showed he had a shower every Wednesday and Saturday evening except Saturday 5/11/24 was marked as refused at 9:12 PM. During an interview with R78 and Unit Manager (UM) Z on 5/15/24 at 11:20 AM, R78 reported he did not get a shower Saturday 5/11/24 or Sunday 5/12/24. R78 expressed frustration that staff did not have enough time to give him a shower on 5/11/24 and did not find time on 5/12/24 as they had promised. UM Z said staff are to report any showers that are refused to the nurse in charge and they are to follow up with the resident and document the refusal in the progress notes. UM Z, said she would look into the concern. Prior to exit UM Z did not provide any additional information. Review of R78's progress notes for 5/11/24 revealed no indicating R78 refused a shower on 5/11/24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intake #MI00143643 and MI00144325. Based on observations, interviews and record review the facility failed to follow standards of care for 5 Residents (R20, R39, R78, R135, R136) out of 28 sampled residents, resulting in R39 not having her lower extremities assessed and evaluated by her physician, R78 not having his wounds treated as ordered, R20 potentially having a serious medication error and R135 and R136 not having a complete set of neurological assessments after a fall. R39 Review of R39's face sheet dated 5/20/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included chronic kidney disease, stage 3, muscle weakness, weakness and need for assistance with personal care. R39 was her own responsible party. R39 was observed in bed on 5/13/24 at 1:28 PM. R48 complained of both ankles being swollen, she poked them with her finger and the skin dented in leaving a mark for a few seconds. R48 was concerned as to the reason and wanted her physician to address this concern. Review of R39's care plan revealed she had a care plan for increased potential with acute condition change with cardiopulmonary, metabolic, or infectious complications related to increased risk for heart attack and/or stroke secondary to HTN (hypertension) and hyperlipidemia (elevated cholesterol), history of UTI's (urinary tract infections) dated 8/14/23. Interventions included assess and document edema, breath sounds, circumoral (around the mouth) or nail bed cyanosis, dated 8/14/24.) The Nursing Home Administrator (NHA) was notified of R39's concern about her ankle swelling and wanting a physician to address this concern on 5/15/24 at 10:46 AM. On 5/16/24 at 10:45 AM, R39 was observed in bed with her feet elevated, she remained concerned about her ankle swelling and again poked her finger into her ankles leaving a indentation. R39 said she has had this ankle problem for 2 to 3 weeks and was still waiting for her physician to address this concern. The NHA was notified again on 5/16/24 at 12:47 PM that she was still waiting for confirmation that a physician was going to address her ankle swelling. Review of R39's medical record revealed failed to provide any indication the facility was addressing R39's swollen ankles until the Surveyor addressed R39's concerns to the NHA on 5/13/24. Upon exit the facility failed to provide any information that R39's swollen ankles had addressed prior to 5/13/24. R78 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R78's face sheet dated 5/20/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: idiopathic aseptic necrosis of right toes (a condition that causes bone tissue to die due to loss of blood flow), idiopathic aseptic necrosis of left toes, weakness and need for assistance with personal care. R78 was his own responsible party. R78 was observed in his room on 5/13/24 sitting in a wheelchair he had black boots with Velcro closures on both feet. R78 explained that he was losing his toes due to poor circulation and the staff were not doing his daily dressing changes. Review of R78's April, Treatment Administration Record (TAR) revealed, Paint necrotic areas and ulcerated areas on bilateral feet with iodine (prevents infection), let dry, place 2 x 2 gauze between the toes on the left foot then wrap both feet with kerlix and secure with tape. Every day shift every other day for wound care, D/C (discontinue) 4/10/24. Treatments were marked as being done on 4/2/24, and 4/8/24. The treatment boxes for 4/4/24, 4/6/24, and 4/10/24 were left blank (indicating the treatments were not done). Review of R78's April, Treatment Administration Record (TAR) revealed, Right medial knee wound: cleanse with saline and gauze and cover with a band aid every other day for wound care. D/C (discontinue) 4/7/24. The treatment was marked completed on 4/2/24 and the boxes were blank for the treatments 4/4/24 and 4/6/24 (indicating the treatments were not done). Review of R78's May Treatment Administration Record (TAR) revealed, Paint necrotic areas and ulcerated areas on bilateral feet with iodine (prevents infection), let dry, place 2 x 2 gauze between the toes on the left foot then wrap both feet with kerlix and secure with tape. Every day , D/C (discontinue) 5/14/24. The boxes for 5/12/24 and 5/13/24 were marked as completed. The boxes for 5/10/24 and 5/11/24 were left blank (not completed). Registered Nurse (RN) Z changed the dressings on R78's toes on 5/15/24 at 11:20 AM. R78 again expressed concern that the dressings were not being changed daily and he had no way to know what time staff planned to change the dressings. RN Z explained the facility had a change in wound care providers and all medical orders for dressing changes occurred with the change in provider and staff were also expressing concerns that it was not clear what shift was assigned to do dressing changes. Upon exit there was no documentation provided that ensured R78 was being provided his wound treatments as ordered. 31771 R20 R20 admitted to the facility 12/22/21 with pertinent diagnoses that included Diabetes Mellitus. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 9:12 AM a medication administration observation was conducted with Licensed Practical Nurse (LPN) O. LPN O was observed at the medication cart preparing the morning medications for R20. LPN O had prepared all the medication listed on the Medication Administration Record (MAR) except for Lantus insulin 25 units to be administered subcutaneously. When asked about this LPN O reported that the night shift nurse (previous shift) had administered the insulin. LPN O did not give a reason why the nurse did not sign out the Lantus in the EMR and indicated that this was not unusual for herself to sign out this medication. LPN O reported that she and the night nurse had talked about it during the shift change report. Review of the MAR for May 2024 for R20 was later reviewed. It was noted that LPN O had signed out as administered by her the Lantus 25 units for the AM dose on 5/14/24 for R20. On 5/16/24 at 11:52 AM an interview was conducted with the Director of Nursing (DON) and Corporate Consultant (CC) U in the office of the Nursing Home Administrator (NHA). The DON was informed of the observation and the interview with LPN O. The DON indicated that signing out medications another nurse had administered was inconsistent with facility practice. 45410 Resident #135 Review of an Admission Record revealed Resident #135 admitted to the facility on [DATE] with pertinent diagnoses which included metabolic encephalopathy (brain function disturbances caused by chemical imbalance in the blood), unsteadiness on the feet, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #135, with a reference date of 4/23/2024 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #135 was moderately cognitively impaired. Review of Resident #135's Accident Report, dated 4/23/2024 at 7:48 PM, revealed Resident #135 sustained an unwitnessed fall and nursing staff began neurological assessments. Review of Resident #135's Neurological Assessments, begun 4/23/2024, revealed checks were missing documentation on 4/24/24 at 6:30 AM, 8:30 AM, 10:30 AM, and 12:30 PM, on 4/25/24 at 00:30 AM, 8:30 AM, and 12:30 PM, and on 4/26/24 at 8:30 AM. Review of Resident #135's Accident Report, dated 4/26/2024 at 4:40 PM, revealed Resident #135 sustained another fall that was heard but not witnessed by nursing staff. Further review revealed neurological assessments continued from Resident #135's fall on 4/23/2024 but did not restart on 4/26/2024. In an interview on 5/16/2024 at 10:48 AM, Corporate Consultant U reported nursing staff should have restarted Resident #135's neurological assessments when he fell on [DATE] as the fall was not witnessed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on 5/16/2024 at 11:09 AM, Registered Nurse (RN) CC reported she was the first nurse to respond to Resident #135's fall on 4/26/2024. RN CC reported she heard a noise, then saw him laying on the threshold of his doorway on his back. RN CC reported she did a set of neurological assessments when she evaluated Resident #135 after his fall and expected his nurse to continue the neurological checks. Resident #136 Review of an Admission Record revealed Resident #136 admitted to the facility on [DATE] with pertinent diagnoses which included heart failure, difficulty walking, and dementia. Review of a Minimum Data Set (MDS) assessment for Resident #136, with a reference date of 4/8/2024 revealed a Staff Assessment for Mental Status score of 3, which indicated Resident #136 was severely cognitively impaired. Review of Resident #136's Accident Report, dated 3/15/2024 at 4:09 PM, revealed Resident #136 sustained a fall and neurological assessments were initiated. Review of Resident #136's Neurologoical Assessments, begun 3/15/2024 at 4:15 PM, revealed the neurological assessment stopped abruptly during the Q 1hr checks after 7:00 PM on 3/15/2024 and were not finished. In an interview on 5/15/2024 at 11:08 AM, Corporate Consultant U reported she was aware Resident #135's neurological assessments for her fall on 3/15/2024 were stopped before being completed and she was not sure why. Corporate Consultant U reported the normal process is to use the paper neurological assessment sheet until all timeframes are completed. Review of facility policy/procedure Accident/Incident Report Fall Management, revised June of 2018, revealed .Following unusual occurrences, vital signs will be monitored as follows . A resident who sustains a head injury or suspected head injury will have the neurological assessment completed as indicated .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interview and record review, the facility failed to assess, monitor, implement pressure relief and treat for wounds and pressures ulcers for 3 Residents (R23, R37, R48,) of 4 resident reviewed for pressure ulcers, resulting in R37 developing an unstageable pressure ulcer on his back and a new pressure ulcer on his right thigh, R48's wound on her leg increasing in size and the pressure ulcer on her buttock worsening, and R23 missing wound treatments/assessments. Findings included: Review of R48's face sheet dated 5/20/24 revealed, she a [AGE] year-old female admitted on [DATE], she had diagnoses that included: pressure ulcer of left heel, unstageable, diabetes mellitus 2, lymphedema, pressure ulcer of right buttock, stage 2, non-pressure chronic ulcer of left calf, weakness, abnormalities of gait and mobility, and need for assistance with personal care. R48 was her own responsible party. During an interview with R48 on 05/13/24 at 1:41 PM, R48 was very concerned about the wound on her left heel, back of her left leg and her buttock. R48 was on her back in bed and the back of her left leg was in contact with her mattress. There were no positioning pillows or devices visible in her room. R48 said she was not able to roll or reposition herself. R48 said staff will not tell her if her wounds are getting worse and she is unable to see her wounds herself. R48 was frustrated with not knowing when the facility was going to do her wound care and she was not aware of her transportation or follow up medical appointments. During an interview with R48 on 05/16/24 at 8:45 AM, R48 was on her back in bed with her left leg flat in full contact of the mattress. R48 was not aware of any turning schedule or plan for pressure relief. R48 said she was not able to roll or reposition herself. There were no positioning pillows visible in the room to support her off her back side. R48 was pleased that she was seen by the wound care staff that morning and had received a written note of her follow up medical appointment for her wounds. Review of R48's Activity of Daily Living (ADL) care plan dated 4/17/24 revealed was dependent for all ADL's and required assistance of 1 person or bed mobility. R48 was not able to walk. R48 required the assistance of 2 person and a lift to get in/out of a wheelchair. R48 was using incontinence products for elimination. Review of R48's potential risk for impaired skin integrity revealed the following interventions: assist with re-positioning with use of a draw sheet as needed to prevent friction/shear, measure open areas upon admission, and weekly, prn (as needed). There was no indication of how often staff were to assist with repositioning. There was no indication of where R48 had skin breakdown and devices to be used to prevent/reduce pressure when repositioning other than cushion in wheelchair, and pressure reducing mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 5/20/24 at 10:27 AM, the DON reviewed R48's medical record. The DON located information that indicated R48 was admitted with skin break down on her left heel, left leg and buttock. The DON was not able to locate any documentation on the wound sizes or stages on admission. The DON reviewed R48's hospital records and could not find full descriptions with size and stages of R48's wounds on the day of discharge. During an interview with the Director of Nursing (DON) on 5/20/24 at 10:27 AM, the DON said R48's left heel was assessed 2 days after discharge and every 7 to 8 days after the first assessment. R48's left heel was assessed to be healing. R48's back of her leg was assessed the day after admission be a vascular wound the measured 3.0 cm x 1.5 cm x 0.1 cm. The wound on R48's back of her left legs was assessed to have increased in size on 4/24/24 6.0 cm x 8.0 cm x 3.2. The DON could not locate any information that explained why the wound was increasing in size, or change in treatment. The last recorded measurements for the wound on the back of R48's left leg was done on 5/16/24, 6.9 cm x 3.8 cm x 0.1 cm. DON could not locate any documentation for the reason the wound had declined. The first assessment for the wound or R48's buttock was completed the day after her admission on 4/18/24, the wound was assessed as healed on 4/24/24. On 5/16/24 R48 was assessed as have a 0.2 x 0.7 x 0.1. There was no indication as to the cause of the wound opening again. The DON said her expectation is a full wound assessment on admission, and weekly. The DON could not locate any education for pressure relief needs, timing or risk/benefit discussion when R48 was requesting to stay up in her wheelchair. 31771 R23 Review of the Admission Record reflected R23 admitted to the facility 11/15/23 with diagnosis that included End Stage Renal Disease (on dialysis), Dementia, and History of Stroke. Review of the Admission Minimum Data Set (MDS) dated [DATE] reflected R23 received nutrition through a feeding tube. The MDS reflected R23 was at risk for developing pressure sores and admitted with one stage 2 pressure sore. Review of the Skin assessment dated [DATE] reflected moisture associated skin damage (MASD) of the sacral area. Review of the Skin assessment dated [DATE] reflected MASD of the sacral area and the addition of a stage I wound on the left ankle measuring 1 x 0.5 centimeter (cm). Review of the Physician Assistant (PA) documentation dated 1/31/24 revealed an open wound on the right hand. The PA documented that the facility identified this wound on 1/12/24 although the Skin Assessment of 1/17/24 did not include this finding. The MASD of the coccyx had progressed to a stage 2 pressure injury measuring 0.5 x 0.3 x0.1 cm. Lastly, the wound on the left ankle had increased from the size noted above to 1.8 x 1.8 x 0.1 cm. The PA documented Pressure injury of left ankle, unstageable. The policy provided by the facility titled Skin at Risk Assessment Documentation, Staging, and Treatment last revised 1/2020, was reviewed. The policy reflected, Definitions, Unstageable Pressure Injury: Full-thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the PA wound documentation dated 2/7/24 included evaluation of the above wounds and reflected the new addition of an unstageable right ankle pressure injury. The above PA documentation of 2/7/24 for follow up on the wounds of R23 was given further review. The documentation reflected a wound on the left ankle first identified 1/17/24 and a new wound on (R23's) right ankle. The PA documentation reflected that staff state they stopped the (pressure relieving) boots. The documentation reflected the unstageable wound on the left ankle measured 1.4 x 1.5 x 0.1 cm. The new unstageable wound on the right ankle, identified after staff had stopped the boots, measured 1.1 x 1.3 x 0.1 cm. On 3/1/24 the EMR reflected a Doctor's Order Refer to Wound clinic. Review of the Wound Clinic documentation dated 3/18/24 revealed R23 had bilateral malleolus (outer ankle) ulcers. The documentation reflected the Wound Specialist measured the wound on the left ankle to be 2.4 x 2.2 x 0.3 cm (an increase in size from 2/7/24) and the right ankle wound measured 1.5 x 1 x 0.2 cm. The Wound Specialist recommended a change in treatment using Santyl, Aquacel and soft wraps. The Wound Specialist also documented Patient is in need of protective boots the PRAFO type boots (pressure-relieving boots) and to follow-up approximately one month. Review of the Treatment Administration Record (TAR) for R23 reflected the change in treatment to santyl and daily dressing changes recommended by the Wound Specialist had been implemented. The EMR reflected the one month follow up with the Wound Specialist was scheduled for 4/24/24. However, no documentation was found that this appointment was kept. Also, the medical record does not reflect the PRAFO type boot recommended 3/18/24 were implemented until 5/8/24. This is approximately seven weeks after the Wound Specialist's recommendation. The medical record reflected that in the month following the Wound Specialist evaluation when the recommended PRAFO boots were not implemented the left ankle wound worsened from 2.4 x 2.2 x 0.3 cm in size to 3.3 x 3 x 0.4 cm documented on 4/19/24. Similarly, the wound on the right ankle worsened from 1.5 x 1 x 0.2 cm to 2.0 x 2.0 x 0.1cm. Review of the TAR for April 2024 for R23 revealed that five dressing changes to the left ankle were not documented as completed and four dressing changes to the right ankle were not documented as completed. On 5/16/24 at 12:27 AM an interview was conducted with the Director of Nursing (DON) and Corporate Consultant (CC) U in the office of the Nursing Home Administrator (NHA). The DON reported R23 was wearing padded boots but these were stopped, as noted by the PA on 2/7/24, because the DON felt the boots were the cause of the wounds. The DON reported that the family of R23 felt the wounds were getting worse and R23 was then seen by the Wound Specialist. The DON reported that she was disappointed the Wound Specialist had recommended implementation of the pressure-relieving boots despite documentation that the wounds had worsened. The DON reported she had discussions with the in-house medical provider about the pressure-relieving boots but was not able to provide any documented rationale for not implementing the Wound Specialist's recommendation. The medical record Progress Notes for R23 were reviewed and revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Interdisciplinary Team (IDT) entry on 2/21/24 at 7:55 AM by the Registered Dietician (RD) that R23 continues with impaired skin integrity. R23 has multiple co-morbidities that are compromising healing of her wounds . weight has been stable .Will continue to follow wound healing progression. -IDT entry on 2/23/24 at 10:58 AM by the RD, stable target weight. -IDT entry on 2/26/24 at 2:23 PM, weight has been unstable, fragile skin and palpable bony prominences, (R23) has multiple diagnosis contributing to the unavoidable areas of pressure injury development they are severe protein caloric malnutrition .she requires assistance with mobility .has double incontinence (bowel and bladder) .Her Care Plan has interventions in place to promote wound healing. -IDT entry 3/18/24 at 7:27 AM, (R23) continues with wounds to her right and left ankle .all of which are healing very well. This is the same date R23 was evaluated by the Wound Specialist and a trend of increasing size in wound measurements was documented. The IDT documentation suggests wounds, in general, are unavoidable for R23. However, no documentation was found that indicated why each wound was unavoidable when it was identified. The MDS dated [DATE] Section GG reflects R23 is dependent on staff for repositioning off pressure areas. The Progress Notes do not reflect R23 refuses repositioning or has demonstrated an inability to tolerate repositioning. R23 is dependent on the facility to provide sufficient healing nutrition via feeding tube. R23 has double incontinence, is unable to perform self-care, and is dependent on the facility for monitoring when cleaning the skin of urine and stool is needed. Review of the EMR comprehensive Care Plan reflects, despite the identification of impaired skin and several wounds since 1/11/24, no interventions have been added or revised since the Care Plan for impaired skin was initiated on 11/23/23. Review of the EMR did not reveal that the recommended follow-up Wound Clinic evaluation had transpired. No documentation was found in the EMR that the Wound Specialist had been informed that the recommended PRAFO boots were not implemented, that nine wound treatments during April 2024 were not documented as completed, or that the wounds had worsened. Other than documentation by RD, no IDT documentation was found of efforts to mitigate alleged unavoidable factors or co-morbidities that contribute to impaired skin. As of survey exit no further documentation was provided by the facility. 31197 R37 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R37 admitted to the facility on [DATE] with diagnosis of (but not limited to) bilateral below the knee amputations, traumatic brain injury, heart failure, and neuromuscular dysfunction of the bladder. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R37 was cognitively intact. During an interview on 5/15/24 at 10:36 AM, R37 stated that staff were not changing his dressings to his back and suprapubic catheter like they were supposed to. R37 said he has a foul odor coming from one of them. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 5/15/24 at approximately 10:50 AM, Licensed Practical Nurse (LPN) H and Certified Nurse Assistant (CNA) I repositioned R37 in bed and while he was turned onto his left side, this Surveyor and staff observed a dressing to the mid back that had a date of 5/14/24 on it. There was a scab noted to the right upper leg that was approximately the size of a quarter without a dressing. R37 stated a staff member told him it was like a blister and it had an odor to it. According to the Skin assessment dated [DATE] 4:29 PM there were no open areas or pressure ulcers. According to the progress notes on 5/14/24 at 11:19 PM reflected, While applying biofreeze (muscle ointment) I felt patch on the residents back he has a wound on the middle of his back approximately 2-3 in x 3/4 width. The area was cleaned and dressing was applied. It was also noted he has scabs on the right leg from adhesive and the catheter that was about the size of a quarter. During a follow up interview and record review on 5/15/24 at 10:50 AM, LPN H stated there were no orders entered at this time for the wound care and she would look into it. At approximately 12:30 PM, LPN H confirmed that there were no treatment orders and no short term care plan initiated for the new unstageable pressure ulcer to the mid back or open area to the right thigh. According to the Skin assessment dated [DATE] locked at 1:54 PM, reflected a new open are to the mid back (no measurements) and dressing was applied. A new open area to the right upper thigh area 1 cm x 3 cm left open to the air. The note reflected the wound nurse would follow up tomorrow. According to the Wound Measurement assessment completed on 5/16/24, reflected a new unstageable pressure ulcer to the mid lower back that was 6.8 cm x 1.8 cm x 0.1 cm and a new unstageable pressure ulcer to the right thigh that did not contain a measurement. The facility failed to ensure that newly developed skin issues are thoroughly assessed including a measurement, initiate a short term care plan and obtain a treatment order from the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00144528. Based on interview and record review, the facility failed to: 1) prevent an elopement for 1 of 1 resident (R73) reviewed for elopements and 2) failed to complete post-fall assessments on 1 of 3 residents (R58) reviewed for falls, resulting in R73 leaving the facility unbeknownst to staff, the potential for R73 sustaining serious injuries during the elopement, and the potential for staff not identifying a change in condition timely for R58 which could result in a serious physical outcome post-fall. Findings include: R73 A review of R73's Admission Record, dated 5/15/24, revealed R73 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R73 had multiple diagnoses that included Dementia and Alzheimer's Disease. A review of R73's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 4/15/23, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment that indicated R73 had short-term and long-term memory problems with inattention and disorganized thinking. In addition, R73 had severely impaired cognitive decision-making skills. A review of R73's progress notes, dated 4/10/24 to present revealed the following: - Interdisciplinary Documentation, dated 5/10/24 at 10:55 PM, revealed, Writer (The Director of Nursing) notified of resident outside on facility grounds at approximately 1800 (6:00 PM). Writer interviewed staff and it was reported that [name of R73] was outside at approximately 1800 wearing flannel pajama pants, tee shirt, grip socks and slippers. The temperature outside at that time was 60 degrees and sunny. Upon re-entering the building, [name of R73] was in good spirits and smiling, he agreeably followed staff back into the building where a skin assessment and vital sign assessment was performed. The skin assessment revealed a scratch to his right forearm approximately 5.0 x 0.1 x 0.1 cm (centimeters) and a pinpoint scratch to his left elbow approximately 0.1 x 0.1 x 0.1 cm . - Interdisciplinary Documentation, dated 5/10/24 at 11:22 PM, revealed, This writer (the Nursing Home Administrator) was made aware that resident exited the facility without immediate knowledge of staff before being located on facility grounds and assisted back into the facility by a staff member . A review of R73's Wandering Risk Assessment Scale, dated 4/17/24, revealed R73 scored a 16 (High Risk). The Wandering Risk Assessment also revealed, [Name of R73] wears an exit seeking transmitter to alert the staff when he is exceeding a safe range of movement or attempting to exit the building. He is at risk to wander into others personal space increasing his risk for injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's investigative file for the incident on 5/10/24, revealed the following: - Investigation Summary form, undated, revealed R73 left the facility unassisted on 5/10/24 at 5:12 PM. He was assisted back to the facility with a staff member at 6:22 PM. He did not leave facility grounds and had no injury. He was not observed to be in any distress. However, the summary also revealed R73 had a scratch to his forearm (5 cm x 0.1 cm x 0.1 cm) and a pinpoint scratch to his elbow (0.1 cm x 0.1 cm x 0.1 cm). - Certified Nursing Assistant (CNA) A's written and signed statement, dated 5/14/24, revealed CNA A saw R73 when she came into the facility. She stated the [brand name of exit seeking transmitter] alarm was sounding when she came into the facility, so she shut it off. She stated as she left the lobby area, she did not see R73 leave the facility. - CNA B's written and signed statement, dated 5/10/24, revealed she was getting ready to do her rounds when she answered a phone call. The caller stated there was a male with green socks on trying to get into cars. She stated she immediately told the nurse and facility staff started to do a head count. After doing the head count, they realized R73 was missing. Staff then went outside to search for R73. - CNA C's written and signed statement, dated 5/10/24, revealed she was informed that a resident was missing. She stated a head count was initiated and the staff began looking for R73. She stated she walked over to the Harbor Unit double doors by the Human Resources Office and went out the back door to the outside. She stated as she walked across the alley way, she spotted R73 in a car with the seatbelt on. She stated she was able to get R73 back into the facility, even though he was combative with her when she opened the car door, and he slapped her arms and tried to run her into the walls when they came back into the building. - CNA D's written and signed statement, dated 5/10/24, revealed the staff realized R73 was missing when they went to take him his dinner tray. During an interview on 5/14/24 at 3:10 PM, Daughter ([NAME]) E (R73's daughter) stated the facility lost my father outside the building Friday (5/10/24) night. She stated the facility did not notice R73 was gone until they saw someone did not pull his dinner ticket (prepare R73's meal tray to deliver it to him). [NAME] E stated R73 was gone for over an hour. [NAME] E stated the staff found R73 sitting in a complete stranger's (not an employee's) unlocked car, in the back seat, with his seatbelt buckled. She stated she was told he was found in a parking lot behind the facility that did not belong to the facility. [NAME] E stated she was very upset, as was her whole family, because anything could have happened to R73 in that hour he was gone, and the facility would not have known about it. That's a very bad area. There are shootings and stabbing's in that area. Someone could have shot or stabbed my father. They could have driven off with him and no one would have known. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/24 at 4:50 PM, [NAME] F (another of R73's daughters) stated her mom told her on Saturday (5/11/24) that R73 had gotten out of the facility on 5/10/24. She stated the facility called her mom and left a message saying he got out of the facility, and he was ok. [NAME] F stated her mom told her that the facility made it sound like it was no big deal that R73 got out of the facility. [NAME] F stated when she came in yesterday (5/13/24) she asked staff what happened. They told her they did not know. She stated she called the Nursing Home Administrator (NHA) this morning and asked her about it. The NHA told her that on Friday (5/10/24) at 5:12 PM, a staff member was coming into the facility and 2 seconds after she walked through the door, R73 walked out the door. [NAME] F stated she was told the staff member did not see R73 sneak out of the building when she came in. [NAME] F the NHA told her that they noticed R73 was missing when no one picked up his meal ticket to deliver his dinner to him. The NHA stated they noticed this at 6:12 PM (according to the cameras per the NHA) and it took them 10 minutes to find R73. [NAME] F was told R73 was brought back into the facility at 6:22 PM. She stated therefore R73 was gone for an hour before anyone noticed he was missing. [NAME] F also stated she was told that the facility staff found R73 in an unlocked car behind the facility buckled into the front seat. She stated the NHA told her that it was ok that R73 had gotten out of the facility because he did not go too far. During the interview on 5/14/24 at 4:50 PM, [NAME] F was in tears as she was talking about this incident. She stated, This is a dangerous area. My dad could have been shot by someone. There are shootings around here. Whoever owned that car could have seen him in it and shot him. She also stated she felt R73 could have been abducted off the streets. [NAME] F also stated she asked the NHA if R73 was wearing his [brand name of exit seeking transmitter] at the time. The NHA told her that he was, but it did not go off. [NAME] F asked the NHA why did R73's [brand name of exit seeking transmitter] did not go off when he walked through the exit door if he was wearing it. She stated she was told R73's [brand name of exit seeking transmitter] did not go off because the staff member had put the code in to open the door two seconds before R73 walked out the door. Therefore, the exit alarm would have been deactivated for those two seconds. [NAME] F stated since this incident happened, she noticed R73 had a new [brand name of exit seeking transmitter] on the opposite ankle that the previous one was on. She stated that makes her wonder if R73's [brand name of exit seeking transmitter] had malfunctioned. [NAME] F also stated that there had been twice in the past that they could not find R73 when she came to visit him. She stated one of those times the facility told her that if they could not locate R73 in the building, then she needed to get in her car and search the neighborhood herself for him. However, they did locate R73 in another resident's room at the far end of the hall watching TV with the other resident. A review of the Front Lobby Camera and Harbor Unit Camera footage on 5/15/24 at 1:00 PM with the NHA and another surveyor revealed the following: - R73 come into the camera view on 5/10/24 at 4:54:30 PM (4:54 PM and 30 seconds) (camera time). R73 walked over to the windows on the left side of the door and looked outside. R73 then moved to the windows on the right side of the doors at 4:54:48. - CNA A (as identified by the NHA) walked into the alcove area between the two sets of doors at 4:55:55 PM and was observed putting in the door code to enter the facility. R73 was standing next to the door frame on the right side of the doors at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA A entered the facility and pulled the door shut behind her at 4:55:58 PM. She then turned her back to R73 and was observed putting in a code on the keypad on the inside of the door to the left of the door. As CNA A was putting in the second set of codes R73 opened the door behind CNA A from the right side at 4:56:08. R73 then exited the facility and walked out of view of the camera to the right side of the door. - After putting in the second set of door codes, CNA A walked away from the door and off camera without looking behind her. Soon after CNA A left the area the Front Lobby Camera was covering, another resident (R58) was observed pushing on the front door and the door did not open (was locked). - R73 was observed on the Harbor Unit Camera being escorted back into the facility by CNA C at 6:22 PM. During an interview on 5/15/24 at 1:00 PM (during the viewing of the facility cameras), the NHA stated the Front Lobby Camera time stamp is 17 minutes slow (R73 exit time would have been 5:12 PM with the adjusted time per the NHA). She stated the time stamp on the Harbor Unit Camera was in real time. The NHA stated CNA A put in the door code to enter the facility. She stated when CNA A came into the facility and pulled the door close behind her, she must have thought the door was secured. The NHA then stated CNA A then put in the [brand name of exit seeking transmitter] code to shut the alarm off (the alarm was sounding because when CNA A entered the facility R73 was standing next to the door). The NHA stated CNA A must not have realized that a resident can still get out the door after she puts in the [brand name of exit seeking transmitter] code because it takes a couple of seconds for the lock to re-engage after the code is entered. The NHA stated CNA A should have seen R73 and realized that was why the alarm was going off instead of assuming the door was secured and the alarm was only going off because a resident was close enough to the door to set it off. 31771 R58 Review of the facility Admission Record reflected R58 admitted to the facility 6/23/22 with diagnoses that included: Alzheimer's Disease, Dementia, and Weakness. Review of the Minimum Data Set (MDS) dated [DATE] reflected R58 is severely cognitively impaired but is independent for ambulation. On 513/24 at 2:00 PM, R58 was observed walking in the hall and was noted to have extensive facial bruising. Purple bruising with yellow edges from the nose under the right eye that extended to the outer right orbit. Also bruising above the right and left eye that extended into the hair line with the lower portion purple and fading to green and yellow. Bruising also was observed lateral to the left eye. Review of the Electronic Medical Record (EMR) revealed a Progress Note dated 5/10/24 at 1:49 AM that bruising was noted to the right side of the forehead of R58. The note indicated vital signs were taken. The EMR did not reflect a neurological assessment, or a Fall Assessment was conducted, or that the Medical Provider or the Responsible Party had been notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Neurological Assessment form for R58 reflected it had been initiated 5/13/24 for the incident that occurred on 5/10/23. The instructions on the form directed initial neurological checks are to start at the acute phase (time of incident) and in 15-minute intervals with decreasing frequency over time for a total of seven days. Review of the EMR reflected a Progress Note dated 5/14/24 at 10:23 AM an additional assessment of the bruising had been conducted. Another Progress Note entry that day at 10:38 AM reflected the Medical Provider and the Responsible Party were notified on 5/13/24 which was three days after the incident. On 5/16/24 at 11:52 AM an interview was conducted with the Director of Nursing (DON) and Corporate Consultant (CC) U in the office of the Nursing Home Administrator (NHA). CC U reported that the nurse did not complete a full Fall evaluation, an Incident Report, or had started serial neurological checks after an unwitnessed fall with facial bruising. CC U acknowledged that the nurse should have initiated these. The policy provided by the facility titled Accident/Incident Report Fall Management last revised 6/18 was reviewed. Review of the document reflected the It is the policy of this facility to complete an accident/ incident report for unexplained bruises or abrasions, accidents, or incidents where there is injury or the potential to result in injury, falls . And Accident/ Incident Reports are reported to the health care practitioner and authorized resident representative as soon as possible. And Procedure: 1. Licensed personnel are responsible for the initiation and completion of the Accident/ Incident Report. And 4. D. Assessment of head injury with initial neurological evaluation if indicated. And 7. Notify the family and health care practitioner as soon as possible with assessment findings and document the notification post fall. On 5/15/24 at 9:22 AM an email request was sent to the NHA requesting the job descriptions for Licensed Practical Nurses and Registered Nurses. The facility provided the undated document titled Nurse Supervisor Job Description and Performance Standards. The document reflected the Purpose of this position included to provide and coordinate nursing care in compliance with facility policies and procedures and to assess residents and take appropriate actions. The document reflected The primary functions and responsibilities of the position are as follows: these included 1. Follow established standards of nursing practices and implement facility policies and procedures, .4. Obtain report from nurse being relieved and record sufficient information for follow-up action as necessary, 5. Provide report to nurse coming on duty, including sufficient information for follow-up action as necessary. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Approximately ten nursing shifts had transpired from the date of incident on 5/10/24 until 5/13/24 before the serial neurological assessments were initiated. This indicated that the incident and expected follow up monitoring of R58 was not included in shift to shift reporting as directed by the Nurse Job Description. However, the delay in initiating the serial neurological checks, the delay in completing the Accident/Incident Report, and the delay in notifications reflected that the information was not passed on shift to shift but also that licensed staff did not question the obvious bruising to the face of R58. This Resident, known to frequently walk the hall, can easily be observed by staff who are also in the hall Following the initial Progress Note entry of the incident on 5/10/24 two observations were documented in the EMR of R58 ambulating in the hall with only entry of 5/11/24 at 9:18 AM noting the facial bruising. However, no documentation in the EMR revealed that a licensed nurse had identified or documented that appropriate action needed to be taken to Follow established standards of nursing practices and implement facility policies and procedures as indicated in the Nurse Job Description provided by the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 Based on observation, interview, and record review, the facility failed to follow physician orders to clean and flush a catheter for 1 (R37) of 4 residents reviewed for catheter care and management. Findings include: R37 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R37 admitted to the facility on [DATE] with diagnosis of (but not limited to) bilateral below the knee amputations, traumatic brain injury, heart failure, and neuromuscular dysfunction of the bladder. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R37 was cognitively intact. During an interview on 5/15/24 at 10:36 AM, R37 stated that staff were not changing his dressings to his back and suprapubic catheter like they were supposed to. R37 said he has a foul odor coming from one of them. During an observation and interview on 5/15/24 at approximately 10:50 AM, Licensed Practical Nurse (LPN) H was observed as she changed the suprapubic (SP) tube dressing. LPN H removed the old dressing and used a partially open pack of 4 x 4 gauze pieces to wipe around the tube. LPN H stated she peeled the corner of the package open and pre moistened them with Normal Saline and then completed the dressing change. According to the orders the area should be cleansed with soap and water. According to the Treatment Administration Record (TAR) for April 2024 and May 2024 reflected, SP catheter site: cleanse with soap and water, cover with a drain sponge every evening shift for cath (catheter) site care. This treatment was not signed out as done on the following days and there were no corresponding progress notes as to why the treatments were not done on 4/19/24, 4/20/24, 4/21/24, 4/23/24 and 4/30/24. According to the April 2024 TAR, SP Catheter-every shift empty foley catheter drainage bag Q (every) shift & record output, There was a spot to record this data 3 times daily. There was nothing recorded for the day shift on 4/4/24, afternoon and night shift for 4/19/24, and the afternoon shift for 4/20/24, 4/21/24, 4/30/24. According to the April 2024 and May 2024 TAR there was an order to irrigate the catheter that reflected, Acetic Acid Irrigation Solution 0.25% (Acetic Acid) Use 60 cc via irrigation two times a day for S/P (suprapubic) catheter flush. This treatment was not marked as completed on the AM shifts of 4/4/24, 4/8/24, 4/21/24, 5/1/24, 5/7/24, and 5/9/24 and there were no corresponding progress notes as to why the treatments were not done.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview and record review, the facility failed to provide palatable food for 1 Resident (R48) of 28 sampled residents, resulting in the potential for poor nutrition and poor wound healing. Findings included: Review of R48's face sheet dated 5/20/24 revealed, she a [AGE] year-old female admitted on [DATE], she had diagnoses that included: pressure ulcer of left heel, unstageable, diabetes mellitus 2, lymphedema, pressure ulcer of right buttock, stage 2, non-pressure chronic ulcer of left calf, weakness, abnormalities of gait and mobility, and need for assistance with personal care. R48 was her own responsible party. During an interview with R48 on 05/13/24 at 1:41 PM R48 was very concerned the food being cold and not being able to eat food that was cold. R48 said she tells the staff, but they do not have time to reheat her food, so she just does not eat. R48 was observed in bed on 5/16/24 at 9:01 AM, R48's breakfast tray was in front of her and looked untouched but R48 said she had taken a bite of her omelet but it was cold so she would not eat it. R48 said she asked staff to heat it up but they said they did not have time. During an interview with Dietary Manager (DM) DD on 5/16/24 at 9:01 AM, DM DD said he was aware R48's complaint of cold food and said he had completed a resident concern form. DM DD provided a copy of R48's concern form dated 5/9/24 about cold food. DM DD said he had not followed up with R48 yet, but staff had been instructed to reheat her food when she requested. DD was informed that R48 is reporting staff do not have time to reheat her food and it remains and ongoing concern.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record reveiew, the facility failed ensure 1 resident (R64) of 1 Resident reviewed for therapy services, had follow up appointment related to medical equipment needed for physical therapy, resulting in pain and frustration with the use of the equipment. Findings included: Review of R64's ADL (activities of daily living) care plan revealed he was [AGE] years old and had diagnose that included encephalopathy (brain disease) and epilepsy (seizure disorder), Left above the knee amputation. No interventions for staff to assist him with his prothesis were located. Review of R64's discharge care plan revealed that on 9/19/23 his guardian agreed with a long term plan for nursing home care. During an interview with R64 on 5/13/24 at 12:52 PM he expressed frustration with the facility not assisting him to get adjustments completed on his prosthetic leg, he explained he stopped using it because it hurt. R64 said the therapist wanted him to keep the leg all day but it dug into his groin. R64 said when he would not leave it on all day they stopped therapy. On 5/15/24 at 9:01 AM the Nursing Home Administrator (NHA) was notified of R64's concern about needing adjustments on his prosthesis. Review of R64's Physical Therapy Evaluation and Plan of Treatment dated 2/8/24 revealed, Clinical Impressions: Pt (patient) referred to PT (Physical Therapy) due to fall during functional transfers; also expressed desire to be able to use L (left) prosthetic leg. Pt (patient) presents upon PT eval with tightness in bilat (bilateral) hip flexors for sitting in w/c (wheelchair) mostly, forward lean in standing with FWW (front wheeled walker), decreased coordination impacting safety with functional transfers. Pt educated on importance of wearing L (left) prosthetic leg during the day and not just during therapy in order to incorporate use of prosthetic leg with functional tasks. PT verbalized understanding of POC (plan of care). There was no indication R64's guardian was involved in the therapy plan of care. Review of R64's Physical Therapy note dated 2/13/24 revealed, Orthotic/Prosthetic Mngmt (management): instruction in proper use, care and wearing time of device, analysis/checkout of patient's response to wearing orthotic/prosthetic device, instruction in proper use, care and wearing time of prosthetic device and techniques to inhibit abnormal movement patterns. Patient required max to total assist to donn (put on) prosthetic. *There was no indication of expected wearing time, tolerance to wearing or indication the facility staff were instructed to assist R64 with the use of his prosthetic leg or that R64's guardian was involved to advocate for R64. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R64's Physical Therapy note dated 2/9/24 revealed, Therapeutic Activities: transfer training to increase functional task performance, dynamic balance activities while standing and facilitation of position in space with cues for trunk and hips extension to reduce UE's (upper extremities) lean of FWW (front wheeled walker). Pt tolerated 1 min. (minute) x 3 reps (repetitions)m 40 sec (seconds) x 1 with FWW. Review of R64's Physical Therapy note dated 2/12/24 revealed, Pt (patient) able to take 4 steps with prosthesis on and used 2ww (2 wheeled walker). Pt required instruction in standing upright, right knee ext (extension) and weight shifting. Review of R64's Physical Therapy note dated 2/13/24 revealed he was progressing with the use of his prothesis and again was provided instructions with wearing time (no specific times given). There was no indication facility staff were trained to assist 64 with putting the prosthesis on or wearing time. Review of R64's Physical Therapy noted dated 2/16/24 revealed R64 was discontinued from therapy per his request (no reason why R64 was refusing to do therapy or indication his guardian was notified or assisted to advocate for him was located). During an interview with the Director of Nursing (DON) on 5/16/24 at 10:00 AM a note dated 12/23/23 was reviewed from the company doing the adjustments on the prostetic for R64's and indicated R64 was to return on 1/8/24. The DON said she would follow up to see what was happening. On 5/16/24 at 11:12 AM the DON provided documentation that indicated R64 did have the follow up appointment on 1/8/24 and they recommended returning on 4/2/24. The DON said the facility could not provide transportation on 4/2/24 and she would work on setting up another appointment today. Upon exit the facility did not provide any additional information that would indicate R64 should not continue to use his prothesis or continue with adjustments. No information was provided on any staff assistance being provided to assist R64 with his prothesis other than Physical Therapy. During an interview with R64's legal guardian on 5/16/24 at 11:26 AM, EE, was able to recall he had talked to R64's therapy staff in the past but could not recall dates or specific information. EE did not recall knowing R64 was still requesting to use his prothesis and still needed adjustments. "EE was supportive of assisting R64 with his needs and said he would follow up to assist the facility with whatever R64 needed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00142853 and the annual survey Based on interview and record review, the facility failed to maintain complete and accurate medical records for 3 of 29 (R5, R26, and R137) sampled residents, resulting in the potential for providers not having an accurate and complete picture of the resident's stay at the facility. Findings include: R137 A review of R137's Admission Record, dated 5/14/23, revealed R137 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R137 had multiple diagnoses that included toxic encephalopathy (brain swelling caused by an infection or exposure to toxic substances), vascular dementia, depression, anxiety, and cognitive communication deficit. A review of the facility's investigative documentation for an incident on 2/8/24 revealed the following: - Facility investigation, undated, revealed a CNA (certified nursing assistant) staff member stopped by R62's and R137's room because she did not observe R62 in his bed where he had last been seen a little while before. When the CNA went into R62's and R137's room, she saw R62 coming from R137's side of the room. She also observed R137 had an open area to his eyebrow. The CNA stated R137 indicated that he and R62 had been arguing and then R62 punched him. However, the incident was not witnessed by staff. - CNA J's written and signed statement, dated 2/8/24, revealed she was checking on R62 and R137 because she had not seen R62 in his bed. She stated as she was walking into their room, she noticed R62 coming from R137's bedside. CNA J stated R62 looked angry and his fist was balled up. She stated she asked R62 what happened, and he stated he did not know. CNA J stated she went to see R137 and he was hurt and she then called for help. - CNA K's written and signed statement, dated 2/8/24, revealed she saw a CNA enter R62's and R137's room. She heard the CNA yell for help and when CNA K walked in the room, she saw R137's head was bleeding. She walked R62 out of the room and took him to the TV room. - A review of R137's progress notes, dated 1/8/24 to 3/8/24 and 3/5/24 to present, revealed the following: - Interdisciplinary Documentation, dated 2/9/24, revealed, Resident A&O x1 (alert and oriented to self) with confusion noted. Denies pain . Steri strips to LEFT eyebrow laceration intact. No drainage noted. Neuro (neurological) assessment WNL (within normal limits). Resident is resting in bed with eyes closed. Respirations even and non labored. Call light in reach. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* No note in medical record regarding the incident on 2/8/24. However, the progress note mentioned steri strips to left eyebrow laceration, but not a possible cause of the laceration. A review of R137's Skin Assessment, dated 2/8/24, revealed, Left eye laceration 2 cm and little redness . However, the Skin Assessment form did not indicate the reason for the skin assessment (e.g., routine or post-incident assessment). During an interview on 5/14/24 at 2:25 PM, Licensed Practical Nurse (LPN) O stated if there is an incident, such as a resident-to-resident incident (e.g., a physical and/or verbal altercation between residents), she would de-escalate the situation, separate the residents, and report the incident to the Nursing Home Administrator (NHA) or on-call person if it occurs after hours. LPN O further stated she would do a skin assessment on the residents and notify the responsible parties (if the resident(s) are not their own persons). LPN O also stated she would fill out an incident report and document the incident the residents' medical records (e.g., progress notes). During an interview on 5/14/24 at 2:30 PM, LPN P stated if there were an incident between residents, she would separate the residents and she would put the residents on 1:1 supervision (a staff member continuously watching the resident) until they could determine a course of action for them. She stated she would immediately contact the NHA or whoever was in charge and notify them of the incident. LPN P stated she would also do a skin assessment on the residents, get vitals (e.g., blood pressure, pulse, respirations), contact their families, and contact the physician. She would also contact the police. We contact the police for every incident no matter what it is. LPN P finally stated she would complete an incident report and document the incident in the residents' medical records. During an interview on 5/14/24 at 3:30 PM with the NHA and DON, they both stated all incidents should be documented in the resident's medical record. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice . Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care . Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings . (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org). 28101 R5 Review of R5's face sheet revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included dementia, glaucoma and anxiety disorder. R5 was not his own responsible party. Findings included: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with R5 on 5/15/24 at 8:45 AM he complained about the way the second shift staff put him to bed. He reported he almost fell . Unit Manager UM Z was notified of this concern and R5 also reported at that time that this had happened on another occasion. R5 also reported that he had been molested by a resident. During an interview with R5's guardian on 5/14/24 at 11:31 AM, R5's guardian said R5 had been making allegations about rough transfers and being molested since he was in the last nursing home. Review of a facility reported incident, dated 5/13/24 at 1:45 PM, for R5 revealed, R5 had concerns about someone molesting him and someone throwing him in bed. Review of R5's progress notes for 5/13/24 revealed no progress notes on that date. Review of R5's progress notes for 5/14/24 at 5:28 PM revealed, R5 reported multiple concerns which met criteria for BHS (reporting to the State Agency) reporting. No indication of the actual concerns. 37872 R26 A review of R26's Admission Record, dated 5/16/24, revealed R26 was an [AGE] year-old resident admitted to the facility on [DATE]. In addition, R26 had multiple diagnoses that included Chronic Obstructive Pulmonary Disease, Weakness, Dysphagia Oropharyngeal Phase, Muscle Weakness, Acquired Absence of Left Leg Above Knee, Diabetes mellitus due to underlying condition with diabetic polyneuropathy, and Phantom Limb Syndrome with Pain. During an interview on 05/14/24 at 11:20 AM, R26 was found in Bed 1 a few doors down from her assigned room. R26 revealed she was in here recouping from yesterday/last night. R26 stated that while she was in the dining room last night (5/13/24) the following incident occurred, my roommate (Name of R7) came into the dining room on her power chair and threatened to hit me, she blew up on me. She was in the dining room yelling, swearing, and shaking her fist at me. To protect me they took her out of the dining room and had me stay in this room last night. Resident further stated, My roommate just yells at me and has threatened to hit me multiple times. I told staff multiple times, but they didn't do anything about it. R26 further revealed she does not like confrontation, so she kept her mouth shut while it was going on. On 5/14/24 at approximately 12:30 PM a review of R26's Electronic Medical Record (EMR) occurred. R26's EMR reflected no incidents of any kind were documented between 5/09 - 5/14/24. During an interview on 05/16/24 at 02:01 PM with R26's Responsible Party (RP) AA revealed, I was in to visit my mom on Mother's Day. During the visit I went back to my (Name of R26's) room and I saw smoke. (Name of R7) was vaping in their room so I reported it. My mom (R26) felt she was going to be yelled at and reported to me yesterday (Name of R7) came into the dining room after dinner on Monday and started screaming and yelling at her. My mom was relocated to another room for the night. I think (Name of R7) took it out on my mom because I reported her vaping to the staff. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/24 at 12:44 PM, NHA revealed I was standing in dining room when it happened. (Name of R7) rolled into the dining room and was not making sense. She was asking (Name of R26) if she was talking smack behind her back. (Name of R26) didn't want to talk and she was not acknowledging her. (Name of R7) was upset and trying to talk so I just separated them. That night we had R26 room w/another resident so we could separate them and let things could cool down. NHA further stated, that (Name of R7) was being very loud and that there was no yelling, shaking of fists, or threats of any kind. NHA did confirm that a note should have been documented in (Name of R26's) record.

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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. 31771 Based on observation, interview, and record review, the facility failed to maintain clean and sanitary medical equipment at bedside for one Resident (R53) reviewed, resulting in the potential for the use of an unsanitary medical device. Findings: The Minimum Data Set (MDS) for R53 dated 3/25/24 Section K reflected R53 has a feeding tube. Section K also reflected R53 received 26 to 50% of the total calories received through the feeding tube. On 5/13/24 at 11:23 AM, R53 was asleep in bed. Observed on the night stand next to the bed was a graduated vessel and a large syringe used for the Resident's feeding tube. It was observed that the vessel was dated 3/30/24 and contained a sticky substance in the bottom of the vessel. The large syringe was not dated. An off-white substance, assume left-over nutritional material, remained at the bottom of the syringe barrel, and filled the tip of the syringe. This indicated that the undated syringe had not been cleaned after the last use. On 5/13/23 at 2:30 PM an interview was conducted with the Director of Nursing (DON) in the room of R53. The DON was asked about the condition of the dated graduated vessel with the sticky substance in the bottom and the undated syringe with the off-white matter in the barrel and the tip. The DON reported that she did not think that R53 was still receiving nutrition through the feeding tube but only flushes. The DON acknowledge that the unclean medical equipment should have been discarded. However, on leaving the room the DON did not discard these items and they remained at bedside for use. On 5/14/23 at 11:28 AM and again on 5/16/24 at 9:18 AM the graduated vessel dated 3/30/24 and the undated syringe with the off-white material in the barrel and tip remained at the bedside of R53. Images retained.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 45410 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) completed specialized training in infection prevention and control, resulting in the potential for knowledge deficits pertaining to current infection prevention and control standards and infectious disease outbreaks. Findings include: According to the Centers for Medicare and Medicaid Services (CMS) Infection Prevention, Control & Immunizations pathway, dated April of 2024, the designated Infection Preventionist is required to complete specialized training in infection prevention and control prior to assuming the role of the Infection Preventionist. In an interview on 5/16/2024 at 1:02 PM, the Director of Nursing (DON) reported there was not currently an employee with specialized training in infection prevention. The DON reported Registered Nurse (RN) Unit Manager Z is the new facility IP and had been working on her IP certificate but had not yet completed her certificate. RN Unit Manager Z reported she took over as the IP a few months ago and had been working on her IP certificate but had not yet taken her test for completion of the certificate.