STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235139	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avista Nursing and Rehab	2901 Galaxy Dr Saginaw, MI 48601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 38471 Based on observation, interview and record review, the facility failed to act upon grievances reported in Resident Council meetings and provide responses to grievances as reported during Resident Council with the potential to affect all residents that attend the council meetings, resulting in, unresolved resident concerns and a decreased quality of life. Findings Include: During Resident Council on June 4,2024 at 3:30 PM, the four residents in attendance were asked if their concerns voiced in the meetings were followed up on and resolution/update provided at the next scheduled meeting. The attendees reported staff will ask generalized questions regarding if their issues have been resolved but there is no other discussion past issues or how the facility will resolve them. On 6/5/2024 at approximately 9:00 AM, a review was completed of Resident Council Notes from June 2023 to May 2024. While residents voice their concerns in resident council the notes did not specify the issues with that specific discipline. Furthermore, there was not a response documented to the residents' concerns voiced at the next meeting, via concern form or other methods. June 12, 2023: Dietary: Five residents had food palatability and portions concerns. Therapy: Four residents had concerns with lack of therapy services. Nursing: Three residents expressed concerns. Social Services: Three residents had concerns regarding the social worker. Housekeeping/Laundry: Two residents expressed concerns with the cleanliness of their rooms. July 10,2023: Nursing: One resident expressed concern but the documentation was not clear as to the resident's issue. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Housekeeping/Laundry: Two residents had concerns regarding missing clothing and lack of towels when showering. Dietary: Had varying complaints on staff following preferences and palatability. August 10, 2023: Residents expressed they were not offered night snacks. Housekeeping/Laundry: One resident had concerns regarding missing clothing. Dietary: Had varying complaints on staff following preferences and palatability. September 11, 2023: Snacks are not available at the nurse station and aides say there are not any snacks. Housekeeping/Laundry: One resident had concerns regarding a missing blanket. 10/10/2023: Therapy: Three residents expressed concern. 11/9/2023: Social Services: One resident expressed concern, but said concern was not detailed. Activities: Two residents expressed concern with the program but it was not elaborated upon. Dietary: Two expressed resident concerns. Therapy: Seven resident had concerns for lack of therapy services. Maintenance: Three residents expressed concern, but staff did not annotate what the problem was. 12/11/2023: Dietary: Concern with food being cold. Therapy: One resident requested a walker or cane. Maintenance: Residents stated there was metal sticking out his bed. 1/10/2024: Dietary: Concern regarding food being cold. 2/10/2024: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary: Three residents had specific concerns regarding their food preferences. Nursing: One resident stated he was not being administer his medications timely. Housekeeping/Laundry: One resident had concerns as her laundry was being dyed different colors. 3/5/2024: Therapy: One resident expressed wanting to be reassessed for therapy services. 4/4/2024: Maintenance: Resident stated his television needed to be fixed. 5/8/2024: Resident suggested placing an ice machine in the dining room. On 6/5/2024 at an interview was conducted with Activities Director O regarding resident concerns voiced during resident council. Director O stated when residents bring up a concern during the meeting she will bring the issue to morning meeting the following day and the concerns are addressed during caring partner rounds. This writer and Director O reviewed Resident Council notes and found once an issue was stated there was no documented follow up. Director O clarified there was no documentation that resident concerns from resident council were being addressed and the resolution/update being provided at the next meeting. Review was completed of the facility policy entitled, Grievance/Concern Procedural Guidelines, review 1/2024. The policy stated, .All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including rationale for the response .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to ensure assessment and documentation of incompetency prior to enacting a Durable Power of Attorney (DPOA) and accurate documentation of advance directive forms for one resident (Resident #28) of two residents reviewed for Advance Directives, resulting in DPOA enactment prior to incompetency determination, medical decisions being made for the resident without legal documentation of determination of incompetency, including consent for psychoactive medications and the likelihood for the resident's care wishes to not be followed. Findings include: Resident #28: Record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses which included dementia with behavioral disturbance, dysphagia (difficulty swallowing), osteoporosis, failure to thrive, and difficulty walking. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to maximum assistance to complete Activities of Daily Living (ADL). Review of Resident #28's face sheet in the Electronic Medical Record (EMR) specified, Advance Directive . CPR (Cardiopulmonary Resuscitation) indicating the Resident wished all medical interventions to be completed in an emergent life-threatening medical situation. Review of the form entitled, Advance Directives/Medical Treatment Decisions in Resident #28's EMR detailed the option, I do not choose to formulate or issue any Advance Directives at this time. I want efforts made to prolong my life and I want life-sustaining treatment to be provided was checked. The form included a signature section with spaces for a Facility Representative, Resident, and Legal Representative signatures and dates. The only signature present in the signature section of the form was a facility Licensed Practical Nurse (LPN) with the date [DATE]. Below the signature section, the form included, If legal Representative signed, please complete the following Print Name . Relationship . Type of Legal appointment. This section was completed with Family Member M's name, relationship and indicated their legal appointment was POA (Power of Attorney). A Durable Power of Attorney for Health Care Designation dated [DATE] was present in Resident #28's EMR. The document identified Family Member M as the Resident's patient advocate and detailed, My Patient Advocate is not authorized to exercise any powers conferred under this Designation while I am able to participate in medical treatment decisions. My attending physician and one other physician shall determine, after examining me, when I am unable to participate in making my own medical decisions . Review of incompetency documentation in Resident #28's EMR revealed the date of the second physician signature determining the Resident was incompetent to make medical decisions was completed on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #28's EMR revealed an Informed Consent for Psychoactive Medications form for Seroquel (antipsychotic medication used cautiously in adults with dementia). The consent was signed by Family Member M on [DATE]. An interview was completed with Social Services Director A on [DATE] at 1:30 PM. Resident #28's Advance Directives/Medical Treatment Decisions form was reviewed with Director A. When queried regarding the form not including the Resident's signature in the signature section, Director A indicated Family Member A had signed the form in the Print Name section and stated, Form not completed correctly. When asked how they know that was Family Member M's signature, Director A verbalized understanding and revealed they had not completed the form. Director A was then asked if Resident #28 was deemed incompetent on [DATE] when the form was completed. Director A reviewed the Resident's EMR and stated, Second incompetency determination was signed on ,d+[DATE] (2024). When queried if Resident #28 was not deemed incompetent until [DATE], Director A confirmed. Resident #28's Informed Consent for Psychoactive Medications form for Seroquel was reviewed with Director A. When asked if Family Member A should have signed the Advance Directives/Medical Treatment Decisions form and the Informed Consent for Psychoactive Medications form for Seroquel when Resident #28 had not been deemed incompetent, Director A replied, I would say no. On [DATE] at 2:10 PM, the Administrator was informed of Resident #28's family member signing documentation prior to incompetency determination being completed by two physicians. The Administrator verbalized understanding and indicated they would address the concern. No further explanation was provided. A policy/procedure was requested from the Administrator on [DATE] at 2:10 PM but not received by the conclusion of the survey.

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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** 37668 Based on observation, interview and record review, the facility failed to ensure that hygiene care was provided to two residents (Resident #23 and Resident #28) of four residents reviewed, resulting in a lack of comprehensive documentation and provision of daily care, long, visible facial hair on a female resident, and the likelihood for feelings of psychosocial distress utilizing the reasonable person concept. Findings include: Resident #28: On 6/3/24 at 1:40 PM, Resident #28 was observed sitting in a wheelchair in their room with a food tray in front of them on an overbed table. The Resident was female and had multiple, visible, thick colored hairs on their chin. An interview was attempted to be completed at this time. When spoke to, Resident #28 was pleasantly confused and did not consistently provide appropriate responses to questions when asked. Record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses which included dementia with behavioral disturbance, dysphagia (difficulty swallowing), osteoporosis, failure to thrive, and difficulty walking. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to maximum assistance to complete Activities of Daily Living (ADL), including one person assistance for personal hygiene. On 6/4/24 at 4:00 PM, Resident #28 was observed in their room sitting in a wheelchair. The visible, long thick chin hairs remained visible. An interview was completed with Certified Nursing Assistant (CNA) Q. When queried regarding facility policy/procedure related to removal of facial and chin hair for female residents, CNA Q stated, We ask them first. When queried what they do if a resident refuses to facial hair removal, CNA Q replied, Tell the nurse. When queried if they document if a female resident refuses facial hair removal, CNA Q revealed there was no specific area to document refusal of shaving for females like there is for men. When asked what they meant, CNA Q showed this Surveyor their documentation screen in the EMR. Male residents had a specific section for shaving and female residents did not. The personal hygiene section of the CNA charting included multiple items such as washing face, brushing hair, and shaving. When queried regarding the personal hygiene task documentation in Resident #28's EMR being documented as completed and why the Resident's facial hair was not removed if the task was documented as completed, CNA Q revealed they document the task was completed if any of the items were done. An interview was completed with the Director of Nursing (DON) on 6/5/24 at 11:36 AM. When queried regarding Resident #28's chin/facial hair, the DON indicated the Resident frequently refuses care due to behaviors. When queried regarding documentation demonstrating the Resident had refused hair removal, the DON confirmed there was no specific area for documentation. The DON verbalized understanding. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided policy/procedure entitled, Activities of Daily Living (ADL), Supporting (Reviewed: 9/2023) revealed, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . 39059 Resident #23: On 6/03/24, at 10:08 AM, Resident #23 was resting in bed. Resident #23 had their eyes open and did not respond to verbal communication. On 6/04/24, at 9:15 AM, Resident #23 was resting in bed. Resident #23 had their eyes open. On 6/04/24, at 2:00 PM, a record review of Resident #23's electronic medical record revealed an admission on 10/25/2022 with diagnoses that included Stroke, Developmental disorder and Dementia. Resident #23 was dependent on staff for all Activities of Daily Living (ADL's). A review of the care plan revealed I have an ADL self-care performance deficit d/t dementia, cerebral infarct, hemiplegia . Interventions . I am totally dependent on (2) staff for repositioning and turning in bed . Broda chair for comfort/positioning . A review of the Kardex revealed . PATIENT CARE . change position to offload Alternate periods of rest with activity out of bed . On 6/04/24, at 4:15 PM, Resident #23 was resting in bed. Nurse F entered the room and was asked if Resident #23 gets assisted out of bed and Nurse F stated, yes, she does get up and the aides put her in her reclining chair and they usually placed her near the front office as she likes to look around. On 6/04/24, at 4:32 PM, the Director of Nursing was made aware Resident #23 was in bed since survey began. On 6/05/24 11:26 AM, Resident #23 was sitting up in their reclining wheelchair and appeared comfortable.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview, and record review, the facility failed to implement and operationalize a comprehensive Restorative Nursing program to ensure appropriate assessment, services, and treatment to maintain or improve Range of Motion (ROM) for two residents (Resident #36 and Resident #44) of two residents reviewed, resulting in a lack of ongoing and accurate assessment and documentation of Range of Motion (ROM) and contractures, a lack of implementation of Restorative Nursing services and residents with known contractures and limitations in ROM, and the likelihood for further decline in ROM, functional decline, and avoidable pain. Findings include: Resident #36: On 6/3/24 at 11:05 AM, Resident #36 was observed sitting in a wheelchair in their room. The Resident's right arm was bent at the elbow with their hand in a fist. Their arm was bent upwards and positioned against their chest. The wheelchair had one leg rest on the right side and the Resident's right foot was positioned on the leg rest. Their left foot was on the floor and the Resident was propelling themselves in the wheelchair in their room. An interview was attempted to be completed at this time. Resident #36 made eye contact when spoke to and made unintelligible verbalization and sounds when asked questions. When asked if they could move their right leg, Resident #36 did not provide a meaningful response. This Surveyor proceeded to point to Resident's right leg and ask them if they were able to move it, Resident #36 shook their head indicating they could not. This Surveyor then pointed at Resident #36's right arm and asked the Resident if they were able to move their arm and shook their head to indicate no. Record review revealed Resident #36 was originally admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, severe vascular dementia, and cerebral infarction (stroke) with right sided hemiplegia (one sided paralysis), dysphagia (difficulty swallowing), dysarthria (difficulty speaking), apraxia (brain damage where an individual understands but had difficulty with speech and/or performing tasks or purposeful movements upon request). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and required substantial to maximum assistance with personal hygiene, bathing, and toileting. The MDS also detailed the Resident had one sided upper extremity impaired ROM. A review of Resident #36's previous MDS assessments dated 11/3/23 and 2/3/24 revealed the Resident required partial to moderate assistance for toileting and bathing and had impaired ROM on one side in their upper and lower extremities. On 6/3/24 at 1:52 PM, Resident #36 was observed sitting in their wheelchair in their room. The Resident's right arm remained bent upward at the elbow towards their chest and their hand was in a fist. Their right lower leg remained in place on the footrest. There were no splints and/or braces observed in the Resident's room. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's Electronic Medical Record (EMR) revealed the Resident did not have a care plan in place for Restorative Nursing and/or completion of ROM. A care plan entitled, I have pain r/t (related to) . hemiplegia affecting right dominant side, reduced mobility, contractures affecting right hand and arm (Initiated: 10/26/22; Revised: 2/16/24) was noted in Resident #36's EMR. However, the care plan did not include any interventions related to Restorative Nursing Services and/or ROM exercises. Further review of Resident #36's EMR revealed a care plan entitled, I have an ADL self-care performance deficit d/t (due to) CVA (Cerebral Vascular Accident- stroke), right hemiplegia (Initiated: 10/26/22; Revised: 1/27/24). This care plan included the interventions: - Ambulation: I do not walk (Initiated: 7/12/23) - Bathing/Showering: I require extensive assistance by (1) staff with bathing/showering (Initiated: 1/30/23) - Bed Mobility: I require limited assistance by (1) staff to turn and reposition in bed (Initiated: 3/20/24) - Dressing: I require extensive assistance by (1) staff to dress . (Initiated: 1/30/23; 5/28/24) - Locomotion: I am independent for locomotion with use of high back w/c (wheelchair) with R (right) leg pedal . (Initiated: 9/11/23) - Splint/Brace Right arm elbow extension splint and resting hand splint, when up as I will allow. Skin inspection with donning/doffing (Initiated: 7/12/23; Revised: 6/5/24) Resident #36 had another care plan in their EMR titled, I am at risk for altered skin integrity related to decreased mobility . Hemiplegia affecting right dominant side, use of rt elbow extension splint and resting hand split, right arm trough to W/C (wheelchair), increased muscle tone . (Initiated: 10/26/22; Revised: 11/10/23). This care plan included the intervention, Assist me with donning my Rt (right) arm elbow extension splint and resting hand splint, when up as I will allow. Skin inspection with donning/doffing (Initiated: 1/31/23; Revised: 5/28/24). Review of Resident #36's Kardex and Task documentation in the EMR revealed no tasks and/or documentation related to Restorative, ROM, and/or splint/brace use/application. Review of Resident #36's EMR revealed the Resident was at high risk for contracture development. Additional review revealed the following progress notes: - 12/19/22 at 12:24 AM: Physician/Practitioner Progress Note . Physiatry . No pain or discomfort was noted with a passive range of motion to the right upper extremity contracture . Neurologic: Mental status: Alert, attempting to verbalize. Speech is very difficult to understand Moving left upper and lower extremities with generalized weakness, right upper extremity flaccid, right lower extremity weakness . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 6/20/23 at 7:24 AM: Physician/Practitioner Progress Note . Chief complaints: Functional assessment medications review and clinical evaluation . Patient requires assistance in basic necessities and activities . daily life . requires assistance in cleaning for both upper and the lower half of the body . requires assistance with self-cleaning, grooming and changing. Patient also has difficulty ambulating. Transfers were also quite difficult and requires assistance . Joint examination revealed diffuse scattered deforming joint changes. Flexion contractures . - 8/15/23 at 10:26 AM: Skilled Note . For ADL function . independent for eating (with restorative nursing services to improve ability to eat/consume meals), independent for bed mobility (with restorative nursing services to improve ability to perform bed mobility), independent for transfers (with restorative nursing services to improve ability to perform transfers), independent for hygiene (with restorative nursing services to improve ability to perform hygiene activities), independent for ambulation (with restorative nursing services to improve ambulation/mobility). A review of Resident #36's Health Care Provider Orders revealed no order for Restorative Nursing Services. Resident #44: On 6/3/24 at 10:19 AM, Resident #44 was not in their room. Multiple splints/braces were observed in the room piled on top of their closet. Record review revealed Resident #44 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included Type 1 Diabetes Mellitus (juvenile diabetes or insulin-dependent), anoxic brain damage (brain injury caused by lack of oxygen), convulsions, abnormal posture, and depression. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required maximum to total assistance to complete all Activities of Daily Living (ADL) including eating. The MDS further detailed Resident #44 had impaired ROM in both upper and lower extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 7:47 AM, Resident #44 was observed in their room. The Resident was in bed, positioned on their back. An interview was completed at this time. When queried regarding the level of assistance they require from staff to get out of bed, Resident #44 revealed they are unable to walk and are transferred by staff using a Hoyer (mechanical) lift. Resident #44's arm movements were stiff, and they did not bend their arms at their elbows. Their right hand was visible over and was noted to be open with the fingers spaced and held straight. When queried if they were able to bend their fingers inward to make a fist, Resident #44 revealed they could not. When asked if they were able to bend their elbows, Resident #44 bent their elbow slightly but did not display full ROM. When queried regarding picking up items like a cup or silverware, Resident #44 revealed they were unable to grasp a cup without a handle. Resident #44 then stated, Supposed to have a thing to hook on my hand but I'm waiting on that. When asked what the device was for, Resident #44 revealed they could not hold silverware but the device for their hand would allow someone to hook it on their hand (universal cuff- device that slides over the hand to provide control and independence with eating and other tools). When asked why they were waiting, Resident #44 replied the one they had gotten was too big and the facility was supposed to be getting them a smaller one. Resident #44 was asked if they were able to move and bend their legs and revealed they had minimal movement in their lower extremities. When queried if they were receiving Therapy, Resident #44 revealed they had in the past but not currently. When queried if they were receiving Restorative Nursing services and if the facility staff were assisting them to complete ROM exercises, Resident #44 verbalized that staff used to stretch them and complete ROM exercises, but not anymore. When asked why they stopped, Resident #44 was unable to provide an explanation. Resident #44 then stated, We do chair exercises in activities. When queried if that was part of the facility Activities program, Resident #44 confirmed it was. Resident #44 was asked what they do during chair exercises and revealed they follow along with what they are able to do by themselves. When queried regarding all the braces on top of their closet, Resident #44 confirmed they were braces for their legs and arms. When asked if they wear the braces, Resident #44 replied, When they (staff) tell me. Resident #44 was then asked how they wear the braces and revealed they rarely wear them because no one tells them. On 6/4/24 at 12:19 PM, Certified Nursing Assistant (CNA) T was observed feeding Resident #44 lunch. The Resident had built up silverware on their tray but did not have a universal cuff/adaptor. Review of Resident #44's EMR revealed a care plan entitled, I have an ADL self-care performance deficit r/t h/o (history of) anoxic brain damage, abnormal posturing, muscle weakness, ataxia (lack of coordination and muscle control in arms and legs). I require extensive assist of staff for ADL (Initiated: 4/20/17; Revised: 2/21/24). The care plan included the interventions: - Resident to wear B/L (bilateral) KAFO (Knee, Ankle, Foot Orthosis- brace which extends from the thigh to the foot and is used to stabilize the leg joints, maintain alignment, and assist muscles) daily as I request and tolerated. Skin inspection to be completed prior to donning and doffing (Initiated: 10/9/20; Revised: 3/22/23) - Ambulation: I do not ambulate (Initiated: 7/12/23) - I use Broda chair (wheeled, reclining chair with solid leg/foot rest oftentimes used for positioning) (Initiated: 1/6/18; Revised: 2/2/23) - Transfer: I require total Mechanical Lift with (2) staff assistance for transfers . (Initiated: 4/20/17; Revised: 4/15/24) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bed Mobility: I require extensive assistance by (1) staff to turn and reposition in bed (Initiated: 7/11/22) The care plan also included the discontinued interventions: - Resolved: Passive ROM Wrist flexion extension bend the wrist up and down, affected hand and wrist should be fully relaxed. 10xs (times) hold 3 second to sets BID (Twice a Day). Also use your thumb to slowly open up contracted hand. While cupping the hand with your fingers continue to slowly apply pressure using your thumb to the patient's fingers in the direction of the extension. Be aware that full extension may not be achievable. Proceed as resident will allow. 5xs (times) 5 sec 2 sets BID (Initiated: 7/26/21; Discontinued: 9/23/22) - Resolved: Right wrist support to be applied in the morning, removed at hs (bedtime) . (Initiated: 8/13/18; Discontinued: 1/1/20) - Resolved: I am to wear my CTS brace (brace which holds wrist in neutral position) on left hand during the day time hours . (Initiated: 7/9/21; Discontinued: 9/23/22) A review of Resident #44's Kardex revealed no mention of ROM, Restorative Nursing, and/or brace/splint application. Review of Resident #44's Active, Completed, Discontinued, On hold, Pending Clinical Review, Pending Confirmation, Pending Order Signature, Struck out Health Care Provider Orders in the EMR revealed the Resident did not have a current and/or discontinued order for Restorative Nursing and/or ROM. Further review revealed the Resident did not have an active order for KAFO brace use. Further review revealed the Resident the most recent order for Physical Therapy (PT) was dated start: 8/17/23 and end: 10/12/23. The order specified, Skilled PT 3 x per week . as needed for 8 Weeks . The most recent Occupational Therapy (OT) ordered detailed, Effective 8/17/23, Skilled OT 3 x per week for 8 weeks . (Ordered: 8/18/23; Discontinued: 11/2/23) Review of documentation in Resident #44's EMR revealed the Resident was known to have contractures. Review revealed the following progress notes: - 1/7/22 at 5:41 PM: Nursing/Clinical . Resident noted to have R (right) sided contracture . - 7/25/22 at 4:57 PM: Physician/Practitioner Progress Note . Physiatry (rehabilitation medicine) progress note . The patient was seen for ongoing contracture management . being followed for bilateral lower extremity contracture . uses braces for support . Extremities . Bilateral foot deformity noted. Unable to fully extend the bilateral lower extremity, knee and hip contractures were noted. Tightness of the hamstrings and Achilles noted. Neurologic . Moving all extremities with lower extremity weakness left is greater than right. Weakness of the upper extremities also, hand grasp is poor . Right lower extremity spasticity. Left lower extremity spasticity . (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/16/23 at 9:12 AM: PMR (Physical Medicine and Rehabilitation) Initial Evaluation . Mobility and ADL dysfunction secondary to mechanical fall . (Resident #44) is a [AGE] year-old . Neuro: Mental status: Alert and oriented . Moving all extremities with generalized weakness. Mild contractures of all extremities. Sensation grossly intact to light touch . Patient has high risk for developing contractures . An interview was completed with Licensed Practical Nurse (LPN) P on 6/4/24 at 4:30 PM. When queried regarding the braces observed in Resident #44's room, on top of their closet, LPN P stated, That was from their fracture. When asked what fracture they were referring to, LPN P replied, (Resident #44's) leg got fractured when they were transferred in the facility transport van. LPN P was then queried regarding Resident #44's ROM and revealed the Resident had upper and lower extremity limitations. When queried if Resident #44 was able to grasp a Styrofoam cup to drink from it, LPN P stated, No, not be to grab that but they would be able to use a cup with a handle. With further inquiry, LPN P specified the Resident was unable to close their hand into a fist. LPN P was asked if the Resident had contractures and revealed they were unsure. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Physical Therapy Assistant (PTA) R and Physical Therapist (PT) S on 6/5/24 at 9:43 AM. When queried if Resident #44 was receiving OT or PT, the staff responded the Resident was not. PT S revealed Resident #44 had not been on PT caseload for quite some time. When queried regarding if Resident #44 had contractures, PT S verbalized the Resident had limitations in ROM. When asked if the Resident was receiving Restorative Nursing Services, PTA R stated, No Restorative and verbalized the facility did not have a Restorative Nursing Program in place for ROM. When asked how contracture development and/or worsening of limitations in ROM were prevented if PROM and/or AROM were not completed/performed. PTA R stated therapy staff encouraged residents to complete ROM exercises following therapy discharge. At 9:59 AM, Occupational Therapist Therapy Director D joined the interview. When queried regarding progress note documentation in the EMR indicating Resident #44 had contractures and documentation of PT and OT evaluations and assessments of the Resident, Director D revealed they would need to ask for assistance due to the company switching documentation systems and not having access to prior documentation. The Therapy Staff were then asked if they were assisting Resident #44 to obtain and use a universal cuff for their hand to promote independence and self-feeding, the staff revealed they were not aware the Resident needed the adaptive equipment and indicated Resident #44 preferred to have staff feed them. When queried if Resident #44 was supposed to wear the KAFO brace as indicated in their care plan, Therapy Staff revealed the Resident had not been assessed for brace use recently. When queried regarding the facility process/procedure for Restorative Nursing services including referrals following therapy, Director D then stated that the facility was implementing a walk to dine program for a few residents and were in the beginning stages of developing a Restorative Program. When asked if the facility had a Restorative Certified Nursing Assistant (CNA) and/or staff, Director D indicated floor CNA's were responsible for walking residents on the walk to dine program to the dining room. The Therapy Staff were then asked if Resident #36 was receiving therapy services and PT S responded they were not. When queried if Resident #36 had impaired ROM, PTA R, PT S, and Director D confirmed they did. The staff were then asked where the Resident had impaired ROM and indicated their right arm and right leg. When queried why the MDS assessment dated [DATE] specified the Resident had impaired ROM in one upper extremity but no impairment in their lower extremities, PT S replied that Resident #36 had limited ROM in their right upper and right lower extremities but only had a contracture in their right upper extremity. The Therapy Staff were then asked if the Resident's ROM had improved as the two prior MDS assessments specified the Resident had impaired ROM in one upper and one lower extremity, Director D replied that therapy services do not complete the MDS assessments, and they were unable to provide an explanation. When queried regarding the Resident's contracture and ROM, PT S deferred to PTA R to respond. PTA R replied, Right side Passive ROM (PROM) is okay with active assist (someone else moves extremity). PTA R revealed Resident #36's contracture is in their right upper extremity and detailed they have increased tone in the extremity. Director D revealed Resident #36 tenses and had pain. When queried why the Resident was not receiving ROM to prevent worsening of the contracture and/or additional contracture development, PTA R indicated the Resident has ROM completed when staff assist them to get dressed. When queried if the ROM performed when getting dressed is the same as purposeful ROM exercises to stretch muscles, PT S and PTA R confirmed it was not and did not provide the same benefit as purposeful ROM completion. Director D then stated, (Resident #36) has an elbow splint and hand splint in their room. When queried how frequently staff should apply the splints and how long the Resident should wear them at a time, Director D stated, Per (Resident #36's) choice. When asked what per their choice meant, Director D indicated it meant what the Resident wanted. When queried why the splints were not observed in Resident #36's room and the Resident had not been observed wearing them, a response was not provided. When queried how staff know to apply the splints, Director D responded it was on the Resident's care plan. When queried where staff document splint application, Director D reviewed the EMR and stated, Splints were not on the Kardex, so it does not show for the CNA's (Certified Nursing Assistant) to do and document. Director D indicated they were going to add the splints to the Resident's Kardex. When asked if staff would have to document if the splints were offered, applied, and/or refused if they added it to the Kardex, Director D revealed staff would not have to document application. With further discussion, Director D verified they were unable to track if the splints were utilized or not due to lack of documentation. Resident #36's most recent Physical and Occupational Therapy

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 10:45 AM, Therapy Director D provided OT documentation for Resident #44. Review of the OT Evaluation & Plan of Treatment for Certification Period: 8/14/23-10/9/23 revealed the Resident was revered to therapy for Restoration, compensation, and adaptation and their goal was I want to do more for myself so I can get out of here. The evaluation did not include any assessment/documentation of degree of ROM but indicated upper extremities were within functional limits (WFL- less than normal). When queried how they were able to thoroughly assess and determine if the Resident's ROM is declining without measurements, Director D confirmed they could not. PT and OT documentation for comparison from the previous documentation system were requested again at this time for Resident #36 and Resident #44. On 6/5/24 at 10:49 AM, an interview was completed with the Director of Nursing (DON) and Assistant Director of Nursing (ADON). When queried regarding the facility Restorative Nursing Program, the DON stated, We are working on expanding the program. When asked what they currently had in place, the DON stated, There are a couple people (residents) on functional maintenance. We are working on getting them to walk to meals. The DON was asked if that was the walk to dine initiative Therapy Manager D had referred to and they confirmed it was. When queried who was in charge of the Restorative Nursing Program, the DON replied, (Therapy Manager D) and the MDS nurse. When asked if the facility had a dedicated Restorative CNA, the DON revealed they did not. When queried regarding Resident #36, the DON verified the Resident had a contracture. The DON was then asked why the Resident was not receiving Restorative nursing services and/or specific ROM exercises to prevent further contracture development and/or worsening limitations in ROM and did not provide an explanation. When queried regarding Resident #44 including documentation of contractures, lack of measurements of degree of movement to identify worsening contractures/limitations, and the DON verbalized understand but did not provide further explanation. When asked about the MDS documentation change pertaining to ROM limitations and lack of therapy evaluation to demonstrate, the DON indicated there must have been an error. When queried regarding concerns related to assessment, documentation, and provision of services related to contractures and limitation in ROM, the DON verbalized understanding and reiterated the facility is in the process of developing and implementing a Restorative Nursing Program. No additional PT and/or OT documentation for Resident #36 and/or Resident #44 was received as requested prior the completion of the survey. A policy/procedure pertaining to Restorative Nursing was requested from the facility Administrator on 6/5/24 at 1:29 PM but not received by the conclusion of the survey.

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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** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures to ensure adequate staff training, equipment monitoring, prevention, reporting, investigation, and a thorough analysis of accidents for one resident (Resident #44) of four residents reviewed for falls, resulting in a lack of reporting, thorough investigation, comprehensive procedures to prevent accidents, Resident #44 experiencing a fractured tibia and fibula bones (both bones in lower leg) necessitating emergency medical treatment, unnecessary pain, and the likelihood for decline in overall functioning and health status. Findings include: Resident #44: On 6/3/24 at 10:19 AM, Resident #44 was not in their room. A raised edge mattress was present on the Resident's bed and multiple splints/braces were observed on top of the Resident's closet. Record review revealed Resident #44 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included Type 1 Diabetes Mellitus (juvenile diabetes or insulin-dependent), anoxic brain damage (brain injury caused by lack of oxygen), convulsions, abnormal posture, and depression. Bicondylar right tibia fracture (severe fracture also known as a tibial plateau fracture where the tibia breaks into two or more fragments) and right fibula shaft fracture were added to the Resident's diagnoses on 8/16/23. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required maximum to total assistance to complete all Activities of Daily Living (ADL) including eating. The MDS further detailed Resident #44 had impaired ROM in both upper and lower extremities. On 6/4/24 at 7:47 AM, Resident #44 was observed in their room. The Resident was in bed, positioned on their back. An interview was completed at this time. When queried regarding the level of assistance they require from staff to get out of bed, Resident #44 revealed they are unable to walk and are transferred by staff using a Hoyer (mechanical) lift. When asked if they had fell at the facility, Resident #44 stated, My right leg got broke because they didn't secure me right in my chair. With further inquiry, Resident #44 revealed they were in the facility transport van to go to an appointment and when the driver stepped on the brakes, they slid out of their wheelchair and their leg got broke. When asked what chair they were in, Resident #44 revealed it was the same chair they currently use and indicated the Broda Chair (wheeled, reclining chair with solid leg/footrest oftentimes used for positioning) in the room. With further inquiry, Resident #44 revealed there were two staff present in the transport van when the incident occurred, and the staff picked them up and put them back in their wheelchair. Resident #44 verbalized that by the time they returned to the facility their right leg was extremely swollen and they were in extreme pain. Resident #44 was asked if they went to the hospital and responded that they came back to the facility and then went to the ER. When asked, Resident #44 indicated they were not a candidate for surgery and revealed they returned to the facility with a brace. When queried regarding mobility and movement, Resident #44 revealed their mobility decreased following the accident. (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 Resident #44's Electronic Medical Record (EMR) revealed the following: - 8/15/23 at 11:08 AM: SBAR/Change in Condition . Situation . Falls . Pain (uncontrolled) . Started on 8/15/23 . Morning . Functional Status Evaluation . Changes . Fall . Associated with any suspected serious injury . Edema . RLE (Right Lower Extremity) . Pain . Rate pain on a scale of 0 to 10 (0=no pain, 4-5=moderate pain, 10=excruciating pain) = 9 . Marked localized bruising, swelling, or pain over joint or bone . RLE . Things that make the condition or symptom worse are: movement or palpitation . Send to ER for eval and treatment . - 8/15/23 at 11:59 AM: IDT Note . send to ER for eval and treatment for right leg pain. - 8/15/23 at 12:34 PM: IDT Note . IDT day 1 . Resident was secured and during transport. During this resident was noted to have slid forward and out of chair onto buttocks. Resident returned and further eval and treatment per PCP (Primary Care Provider) at ER . - 8/16/23 at 11:22 AM: IDT Note . Fall note day #2: Resident remains at hospital for observation at this time . - 8/16/23: PMR initial evaluation . Date of Service: 8/16/23 at 1:12 PM . Hospital Course . presented to the acute hospital with mechanical fall, right leg pain and generalized weakness. According to the hospital notes, x-rays of the right ankle and foot showed right distal fibula fracture, x-rays of right tibia and fibula showed right proximal tibia (larger bone in lower leg) and fibula (smaller bone in lower leg) fracture, comminuted (bone broken into three or more pieces) and displaced (bone broken with space between the broken bones). The note reported that when (Resident #44) was on their way to an appointment in Bay City when the seat belt strap on their wheelchair broke, this resulted in (Resident #44) falling out of the wheelchair and their right leg got caught under the wheelchair .seen by an Orthopedic surgeon and was recommended non-operative treatment with right standard hinged knee brace . readmitted . on 8/16/23 . Assessment/Plan . Recommend continuing therapy; Pain 6/10 Oxycodone (narcotic pain medication). Tylenol . - 8/16/23 at 2:23 PM: Nursing/Clinical . Patient arrived from Covenant hospital by stretcher. Patient is readmit due to a rt (right) Tibia and fibula fracture . - 8/16/23 at 3:50 PM: Nursing/Clinical . Upon arrival patient appeared to be experiencing a lot of pain by moaning and crying. I the writer had given patient pain medication which appeared to be effective . (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 requested Incident and Accident (I and A's) for Resident #44 revealed an Incident and Accident Form dated 8/15/23 at 11:25 AM. The form detailed, Fall . Location: Outside . Nursing Description: Resident was out to appointment wearing pick cotton leggings and grey shirt and resident was in specialty chair in van with driver and staff present. Resident was secured in van prior to leaving facility and resident slid out of chair onto floor of van onto buttocks. Resident was placed back into chair and returned to facility. Resident returned to facility and assessment completed and PCP (Primary Care Provider) ordered for eval and treatment. Resident Description: Resident stated that they slid when van turned onto buttocks and did not hit had and stated that . thought was ok when it occurred . Immediate Action Taken: w/c (Wheelchair) assessed and in proper working condition. Van assessed and seatbelts in proper working condition. Education on seatbelt use. Resident was assessment and PCP and family notified and sent to ER for eval and treatment . No injuries observed at time of incident . Witnesses: Certified Nursing Assistant (CNA) V . No additional investigation documentation was provided by the facility. An interview was completed with the Director of Nursing (DON) and facility Administrator on 6/5/24 at 8:02 AM. When queried regarding the incident involving Resident #44 on 8/15/23, the DON revealed they were not in their current position at the time of the accident. The Administrator stated, (Resident #44) went out for an appointment in our van. When the brakes were applied, (Resident #44) slid out of their chair. When queried if the transport van in use when the incident occurred was the same van currently in use at the facility, the Administrator stated, We don't have that van anymore. When queried if the facility reported the incident to the State Agency, the Administrator stated, No, nothing reportable. When asked how the Resident slid out of their chair and broke their leg if they were properly secured in their wheelchair, the Administrator stated, When we went and investigated it, the seat belt buckle clicked but it didn't actually engage. It was able to be pulled apart with a little force. The Administrator continued, When (CNA V) hit the brakes it was enough to come apart. When queried regarding if there were other staff and/or other residents in the van at the time of the incident, the Administrator stated, (CNA V) was the only one in the van. When asked, the Administrator revealed CNA V was a CNA who had recently transferred position in the facility from a CNA to the Transport Staff position. When asked why the Incident and Accident Report specified there were two staff members, the driver and staff member, in the van, a response was not provided. The Administrator was then queried regarding CNA V and revealed they were no longer employed at the facility. When asked the reason CNA V was no longer employed at the facility, the Administrator verbalized their employment was terminated because they did not notify the Administrator immediately of the incident. With further inquiry, the Administrator verbalized CNA V did not notify anyone at the facility until the Resident returned from their appointment. When queried if the facility completed an investigation including interviews/witness statement related to the incident, the Administrator replied, No statements. When asked why they did not obtain interviews and complete a thorough investigation, the Administrator replied, (Resident #44) can tell you what happened. Any facility investigation documentation, other than the Incident and Accident Report, pertaining to the incident as well as CNA V's personnel and training file were requested at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview was completed with Resident #44 on 6/5/24 at 9:09 AM. When queried regarding their right leg fracture in the facility wheelchair van, Resident #44 stated, My legs got caught. When what they meant, Resident #44 explained that their legs went under the bottom of their Broda chair and got caught. Resident #44 then stated, They had to pull my legs out. Resident #44 was asked who was with them in the transport van and pulled their legs out and replied, The driver (CNA V) and (CNA W). This Surveyor proceeded to imitate the calves of their legs being under a chair with their body forward as though on the ground and asked the Resident is that was how their legs were when they fell . Resident #44 confirmed and verbalized their legs got caught under their Broda Chair. When asked where the rest of their body was, Resident #44 revealed they could not really remember because they were focused on their legs. Resident #44 then stated, My right was swollen completely up by the time they got back to the facility. Resident #44 was asked who secured them in the van and buckled the seat belt and replied, CNA V. With further inquiry, Resident #44 revealed the van had a shoulder and lap belt and stated, The one to go across my waist didn't clamp all the way. When asked if the staff member pulled on the seat belt to ensure it was latched or clamped after connecting it, Resident #44 replied, They didn't pull on it. The Resident indicated they heard a click and assumed it was latched. Resident #44 stated, It's my fault. When asked why they felt like it was their fault Resident #44 displayed signs of emotional distress including tearfulness and stated, (The Administrator) told me it was their fault, and they should have checked it. (The Administrator) felt like it was her fault, so I told her it was my fault. I told her I would them (State Surveyors) it was my fault. Resident #44 continued, (The Administrator) cried for days after it happened. She is the only one here for me that love me. When asked if the Administrator had spoken to them following our first conversation, Resident #44 revealed they had and stated, I talked to (the Administrator) about and told her I talked to (State Surveyors) about it. I don't want (Administrator) to get in trouble. Resident #44 revealed they had no where else to go and indicated they were concerned what would happen to them if the Administrator got in trouble. When asked why they were concerned what would happen to them and why they weren't concerned before speaking to the Administrator when they told this Surveyor about the incident initially, Resident #44 did not provide a direct response but verbalized they did not want there to be any confusion. This Surveyor reviewed what they were told by Resident #44 with them. Resident #44 confirmed that was what happened. When queried regarding the van, Resident #44 stated, Got the new bus after that. When asked how long after the accident, Resident #44 indicated it was right away but was unable to provide a specific amount of time. A review CNA V's employee and education file on 6/5/24 at 11:15 AM. The file did not contain documentation of education related to demonstration of competency related to transportation of Residents including securement of Residents and safety belts. The following was present in the file: - Driver Safety Responsibilities document signed by CNA V on 8/9/23. The document included, Seat Belts: A. The driver and passengers are required to wear seat belts and shoulder harnesses . - Van Driver Job Position Description signed by CNA V on 8/9/23. - Employee In-Service/Education Attendance Record dated 8/15/23 and signed by CNA V. The document specified, Summary of Content: Review of Van/Bus Securement of residents. Review of reporting incidents to supervisors at time of occurrence. Review of first aid box and when to utilize and report to supervisor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the DON on 6/5/24 at 11:34 AM. When queried how long the facility has had the new transportation van, the DON replied, Not sure. CNA V was attempted to be contacted via phone at the number provided by the facility on 6/5/24 at 12:45 PM. The phone number provided was not in service. On 6/5/24 at 12:50 PM, an interview was completed with the Administrator and DON. The Administrator and DON were informed that the phone number provided for CNA V was not in service and asked if an alternative phone number was available. When queried what had happened to the transport van that Resident #44 was injured in, the Administrator indicated they thought it had gone to a sister facility but were unsure of the date. Information regarding the facility van was requested at this time including year, model, maintenance documentation, and wheelchair safety belts. The alternative number provided for CNA V was called on 6/5/24 at 1:00 PM. A voicemail message with request for return phone call was left. A review of additional investigation documentation pertaining to the incident involving Resident #44 on 8/15/323 was reviewed. The following information was provided: - Disciplinary Action Form . Date . 8/15/24 (sic) . Nature of Offense . Suspension pending investigation for transport incident . The form was signed by the Administrator on 8/15/24 (sic) and not signed by CNA V. - Transportation Audit form with the columns, Name; Date; Concerns; Initials. The audit form did not specify what was being audited nor did it include the names/signatures of the individuals whose initials were included in the initial column of the form or documentation of training/competency for those individuals. An interview was conducted with Maintenance Director C on 6/5/24 at 1:52 PM. When queried, Director C confirmed they were familiar with the incident when Resident #44 suffering a fractured leg while being transported in the facility van. When queried regarding the Van and the wheelchair securement devices including safety belts, Director C revealed the safety belts for the wheelchairs are not a factory part. Director C verbalized that after the accident occurred, the seat belt was checked, and it made the click sound when inserted but would when pulled without pressing the release button. Director C verbalized that the belt was changed after the accident involving Resident #44. When asked when the belt was changed and when it was ordered, Director C revealed they did not order a replacement as Corporate Maintenance Consultant X had extras on hand and did not have documentation of when the belt was changed. When queried who monitors safety recalls for aftermarket parts such as the safety belt and ensures compatibility, Director C replied, (Corporate Maintenance Consultant X) checks them. When asked if they kept the belt in place which was replaced following the accident, Director C replied that the Administrator had a video on their phone, but they had not kept the belt. When queried how many residents and/or staff the previous van held, Director C replied, Had a bench for two ambulatory residents and one or two wheelchairs, I'm really not sure. When queried regarding routine inspection and/or checks or the transportation van, Director C indicated everything was completed in the facility TELS system for work orders. Documentation related to the transport van in use at the facility in August 2023 was requested again at this 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 W was attempted to be contacted via phone on 6/5/24 at 2:10 PM, A voicemail message with return phone number was left but a return phone call was not received. A follow up interview and review of transportation van documentation was completed with Maintenance Director C on 6/5/24 at 2:15 PM. When queried, Director C revealed they received the documentation from the Administrator. Review of provided documentation related to the transportation van included the following: - TELS work order history with 2008 Ford E350 written on the front - Bus/Van Maintenance Checklist sheet specifying Use the Maintenance Checklist on all Bus/Van Functions. Including Wheelchair lift lubrication and safety check. Schedule major repairs/oil changes accordingly. Dates for monthly Task Completion were included for January to December 2023 with No uploads of logs or Docs written next to the Task Completion section. - Safety Inspection list with a list of items including, 11. Seat belts not frayed, cut or torn and are in good working order. The list also included a Task Completion section which detailed, Marked done on time by (Maintenance Director C) on 9/29/23, 10/31/23, 11/21/23, and 12/29/23. No uploads of logs or Docs was handwritten next to the Task Completion section on the provided documentation. Note: No documentation of Safety Inspection completion was provided for January to August 2023. Maintenance Director C was asked why no Safety Inspection completion task documentation was provided for January to August 2023 and indicated they were not sure. When queried what the did when checking the seat belts during the Safety Inspection and stated, Make sure they aren't frayed or torn. When asked if they connected or latched the belts, Director C indicated they would make sure they click and release when pushed. When queried if they would pull on the belt to ensure it was engaged as part of the Safety Inspection, Director C replied, I do now. When queried regarding transportation staff training, Director C verbalized they show staff how to transport and secure residents in the transport van. When asked if a form or checkoff sheet was utilized as part of the training process to show what each transportation staff member had been trained to do and had demonstrated competency in, Director C stated, Not a check off. Director C was asked how they document and show what tasks staff have been trained and demonstrated competency in without a check off and stated, I understand what you're saying. Do not have one, but I will make one. On 6/5/24 at 3:08 PM, an interview was completed with the facility Administrator. When queried if there was any additional investigation completed and/or documentation related to the accident involving Resident #44, the Administrator verbalized they were attempting to upload the video of the seat belt, but all other documentation had been provided. The Administrator was then asked what time and where the accident occurred where Resident #44 came out of their wheelchair and revealed they did not know. When asked if it was on their way to their appointment in Bay City, the Administrator stated, On their way there. When asked where Resident #44's appointment was in Bay City, the Administrator indicated they were not sure of the specific location. The Administrator was then asked what time the Resident left the facility and returned on 8/15/23. The Administrator reviewed a calendar and other EMR communication notes not accessible to State Surveyors and stated, Pick up time was 7:00 AM and got back around 11:00 AM. When asked, the Administrator confirmed the drive to Bay City was approximately 30 minutes depending on traffic and the specific location of the appointment and the accident which resulted in Resident #44's fractured leg had occurred on the way to the appointment. (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 video provided by the facility was completed. The video did not include a date/time stamp nor any other identifying information to demonstrate the vehicle in which the video taken. In the video, an individual is seen connecting the metal tongue of a seat belt into the buckle. A click can be heard and then the metal tongue is pulled out of the buckle without depressing the release button. An interview was conducted with the Administrator on 6/5/24 at 4:17 PM. When queried if CNA W was in the transport van with CNA V on 8/15/23 when Resident #44 was injured, the Administrator replied they were not sure. Review of EMS documentation for Resident #44 revealed EMS staff arrived at the facility and began assessment of Resident #44 on 8/15/23 at 11:07 AM. The Ambulance left the facility with Resident #44 on 8/15/23 at 11:33 AM and arrived at the hospital ER at 11:50 AM. EMS documentation detailed, Prehospital Care Report . Impressions: Possible Injury: Yes . Provider's Primary Impression : Pain, Right Lower Leg . Swelling, right leg, Unspecified fracture of right lower leg . Medications Administered: Yes . 8/15/23 at 11:32 AM . Fentanyl (narcotic pain medication for severe pain) 25 Micrograms (mcg) Intravenous (IV) . Patient Care Report Narrative . Arrived to find the patient laying in bed . complaining of 10/10 pain to right lower leg . has limited movement of extremities due to a previous CVA (stroke) . (Resident #44) was seat belted in a wheelchair and was being transported in a van . the seatbelt strap broke and fell out of the wheelchair . landed on right side with right leg folded under them. The van driver was able to pick them up and place back onto the wheelchair. (Resident #44) went to their appointment and was then taken back to (facility) . had swelling to right lower leg, pedal pulses were present, and was able to move toes. (Resident #44) can normally pick up that leg but was unable to today . IV established and given Fentanyl. Transported . Review of Hospital documentation for Resident #44 revealed the following: - 8/15/23 at 3:01 PM: ED Provider Notes . presenting to the ED . for evaluation . Per (EMS) the patent was on way to disability appointment in Bay City when the seatbelt strap broke . resulted in falling out of wheelchair and right leg getting caught under the wheelchair. The patient took Norco (narcotic medication for severe pain) at 1040 . for right leg pain and did not experience any relief . Physical Exam . Pain over right tibia. Mild contractures of all extremities . ED Course . Morphine (narcotic medication for severe pain) IV and . Toradol (controlled medication for pain) for pain . 3:40 PM . Versed (benzodiazepine class medication frequently used for sedation, anxiety, and adjunct pain control) IV for pain control . 5:01 PM . Dilaudid (narcotic pain medication) IV for pain control . patient is still symptomatic with comminuted displaced tibial fracture . I am concerned that if discharged today, the current condition will worsen, and an adverse event like severe unrelenting pain may occur . medically necessary hospitalization due to the need for intravenous analgesia, evaluation by Orthopedic surgery . Condition: Guarded . - 8/16/23 at 9:11 AM: History and Physical Examination . Orthopedic surgery was consulted . advised right standard hinged knee brace . admitted for right tibia fibula fracture . Assessment/Plan: Right proximal tibia fibula and right distal fibula fracture. Orthopedic surgery had been consulted, plan for non-operative treatment with hinged brace . should be removed or loosened daily for check for underlying skin breakdown, right heel should be completely off any underlying surface to prevent decubitus (pressure ulcer - wounds caused by pressure), repeat x-rays in 2 weeks, follow-up in the office . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hospital Imaging: XR (X-Ray) Foot . Right: 1. Subtle post traumatic nondisplaced fracture of the distal fibula extending to the lateral malleolus (bone on the outside of the ankle joint) with significant soft tissue swelling. 2. Subtle fractures of the foot cannot be entirely excluded . Signed . 8/15/23 at 1:38 PM Ankle 3+ View Right: 1. Subtle post traumatic nondisplaced fracture of the distal fibula extending to the lateral malleolus with significant soft tissue swelling . Signed . 8/15/23 at 1:35 PM Tib/Fib Right: 1. Acute post traumatic comminuted and displaced fracture of the proximal tibia and fibula with deformity and soft tissue swelling. Follow-up is recommended . Signed . 8/15/23 at 1:15 PM - Knee . Right: 1. Acute post traumatic comminuted and displaced fracture of the proximal tibia and fibula with deformity and soft tissue swelling. Follow-up is recommended . Signed . 8/15/23 at 1:08 PM - Femur 2 View Right . Subtle right femoral neck cortical break cannot be excluded. If there is concern, follow-up CT (cat scan) of the pelvis may be obtained for further evaluation. 2. Partially visualized comminuted fracture of the tibia and possibly fibula . 4. Soft tissue swelling seen . Signed . 8/15/23 at 1:04 PM - XR Portable Pelvis 1-2V: 1. Chronic deformity of the hip joints . Subtle cortical break cannot be excluded. If there a concern, follow-up CT (cat scan) of the pelvis may be obtained for further evaluation . Signed . 8/15/23 at 1:01 PM Review of Resident #44's hospital discharge instructions titled, After Visit Summary dated 8/16/23 at 11:59 AM revealed the Resident returned to the facility with the new medications Oxycodone (narcotic pain medication) 5 milligram (mg) capsules, every six hours as needed, and acetaminophen (Tylenol) 650 mg every four hours as needed. The Resident's home Norco (narcotic) medication was discontinued due to the need for stronger pain management. A return phone call was received from CNA V on 6/17/24 at 7:42 AM and an interview was completed. When queried, CNA V confirmed they did. When asked what happened, CNA V confirmed they were driving the facility transportation van and stated, I believe (Resident #44) had a Social Security meeting at a doctor's office north of Bay City by Kawkawlin. When asked if they assisted and secured Resident #44 in the transportation van, CNA V revealed they took Resident #44 out of the building and got them into the van. With further inquiry, CNA V revealed they took the expressway to go to the appointment and stated, I was getting off the expressway and when I stepped on the brakes, the seatbelt just swung off. When asked what swung off meant, CNA V stated, It just swung off towards the door. It came undone. CNA V was asked if the upper (chest) and lower (lap) belts both came undone and replied, It all connects. When asked, CNA V revealed the shoulder and lap belt connected. When asked if any part of the seat belt remained in place, CNA V reiterated it had come undone and stated, There was no seat belt on (Resident #44) and indicated the Resident came out of the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA V was asked what position the Resident was in and replied, I found (Resident #44) on their back when I could stop. When queried what exit they were at, CNA V replied, The [NAME] Road exit. CNA V verbalized it was not safe to get out of the van on the exit, so they stopped as soon as possible. With further inquiry regarding the Resident's position, CNA V verbalized Resident #44 was on their back on the floor of the van with their legs under their Broda chair. When queried what they did, CNA V stated, We had to get (Resident #44) up. (Resident #44) wanted to go to their appointment no matter what because they wanted to get out of the facility. When queried if they were alone, CNA V replied, No, there was another aide (CNA) there with me. CNA V was asked the name of the CNA with them and indicated they were not sure revealed they could not recall. CNA V was able to provide a physical description of the CNA and stated, She was really new. When queried if it was CNA W, CNA V replied, That sounds like her name! When asked if Resident #44 complained of pain, CNA V stated, (Resident #44) was more in shock, I think. They complained of pain when we got back. When queried regarding the transport van, CNA V stated, They had gotten that van like two or three weeks before, hadn't had a month. When queried how long they had transporting residents in the transport van, CNA V revealed they had recently moved to the transportation position when the incident occurred. When asked about the training they received related to transporting residents in the van including securement, CNA V stated, (The Administrator) gave me papers to sign and the policy which included scheduling and scanning medical records. CNA V explained the Transport position also included scheduling resident appointments and scanning documents into resident EMR's. CNA V was then asked if they had to complete a check off and/or demonstrate competency related to securing residents in wheelchairs in the facility van and replied, No. CNA V continued, The maintenance guy showed me how to buckle the chair in the floor but not the individual seat belt. When asked if different types of wheelchairs had to be secured differently, CNA V indicated all chairs buckled to the floor the same way as far as they knew. When asked if there were any differences in the shoulder/lap safety belt usage/connections for different type of chairs (Broda chairs, standard wheelchairs, reclining high back wheelchairs), CNA V revealed they did not know. When queried how they knew Resident #44's safety belt was correctly fastened and, CNA V replied, When I hook it in (metal tongue on end of belt into buckle), it clicked. CNA V was asked if they pulled on the belt to ensure it was secured after placing on the Resident, CNA V revealed they would adjust the belts as needed but were never instructed to pull on the belts to make sure they were working. When queried if they felt they had adequate training to safety perform the Transportation role, CNA V replied, No. Looking back on it, I didn't. When queried what happened when they returned to the facility with Resident #44, CNA V revealed the Resident was complaining of pain and they informed nursing staff of what had happened. When asked if an investigation was completed, CNA V stated the Administrator had them show her how they hooked the Resident up in the van in their chair and that was when the Administrator realized the seat belt make a click sound when connected but would come apart when pulled. CNA V then stated, I don't think anybody checked the belts at all before it happened. It shouldn't come apart like that. When queried if they provided a statement regarding the incident when it occurred, CNA V revealed they spoke to the Administrator, but they did not want a written statement. When queried regarding the unsigned suspension form in their employee file, CNA V verbalized they had never received a suspension

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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. 39059 Based on observation, interview and record review, the facility failed to ensure assessment, maintenance and care of an indwelling urinary catheter, per professional standards of practice, for one resident (Resident #39), and failed to complete treatment of a Urinary Tract Infection (UTI) for one resident (Resident#18) of four residents reviewed, resulting in an indwelling urinary catheter being maintained in an unsanitary manner, a lack of a urinary catheter securement device, delayed, and incomplete antibiotic therapy with the likelihood of ongoing UTI's with continued and increased Multi-Drug Resistant Organisms (MDRO- infections caused by microorganisms that are resistant to treatment), difficulty in treatment, and a decline in overall health. Resident #18: On 6/04/24, at 9:19 AM, During infection control task, the line listings were reviewed which revealed Resident #18 had been treated for a urinary tract infection (UTI) on 4/24/2024. On 6/4/2024, at 1:30 PM, a record review of Resident #18's electronic medical record revealed a readmission on 4/24/2024 after a discharge to the hospital on 4/19/2024 with diagnoses that included Stroke and recurrent UTI. Resident #18 required assistance with Activities of Daily Living. A review of the physician orders revealed Cefpodoxime Proxetil Oral Tablet 100 MG (milligrams) (Cefpodoxime Proxetil) Give 1 tablet by mouth twice Start Date 4/25/2024 08:00 End Date 5/4/2024 A review of the Medication Administration Record (MAR) 4/1/2024 - 4/30/2024 revealed Cefpodoxime Proxetil Oral Tablet 100 MG (Cefpodoxime Proxetil) Give 1 tablet by mouth two times a day for UTI until 05/04/2024 23:59 1 Tab by mouth twice daily for 18 doses -Start Date- 04/25/2024 The record revealed on the days of Thu 25 0800 2000 Fri 26 0800 there was a 9 documented which revealed the resident did not receive the first dose until Friday 26th, at 8:00 PM. A review of the Medication Administration Record (MAR) 5/1/2024 - 5/31/2024 revealed the resident received the Cefpodoxime Proxetil twice a day on 5/1 through 5/4/2024 with the last dose being at 2000 (8:00 PM) of a total amount of 17 doses. A review of the progress notes revealed the following: 4/25/2024 10:05 (10:05 AM) Note Text: Cefpodoxime Proxetil . Medication isn't available at this time. Checked back up medication wasn't available. Medication has been ordered. Will administer to pt once medication is received. Dr. aware . 4/25/2024 19:34 (7:34 PM) Note Text: Cefpodoxime Proxetil . Awaiting arrival from pharmacy 4/26/2024 08:07 Note Text: Cefpodoxime Proxetil . Awaiting arrival from pharmacy 4/26/2024 14:22 Note Text: ABX (antibiotic) awaiting arrival VIA pharmacy . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan revealed I have altered urinary status-neuromuscular dysfunction of bladder, bladder spasms, incontinence, chronic UTI, strong odor to urine . Date Initiated: 06/05/2021 . Interventions . Monitor/record/report to MD for s/sx of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, foul smelling urine, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated: 06/05/2021 Offer toileting assist during routine rounds, ADL care and PRN. Provide incontinence care as needed Date Initiated: 03/14/2023 Use of incontinence products - I wear an incontinence product: bariatric brief Date Initiated: 06/05/2021 Revision on: 03/31/2023 I may be resistive to and/or refuse care including: Not allowing staff to assist me with toileting/brief changes and incontinence care . Revision on 10/05/2023 . Interventions . Educate on the possible outcome (s) of not complying with treatment or care. Date Initiated: 02/02/2022 . I may be resistive to and/or refuse care including: Not allowing staff to assist me with toileting/brief changes and incontinence care . Revision on 03/15/2024 . On 6/05/24, at 9:18 AM, During infection control task, a record review of Resident #18's electronic medical record was conducted along with IC Nurse B. IC Nurse B explained that they received Intravenous Meropenum in the hospital and was discharged back to the facility on oral Vantin (Cefpodoxime Proxetil). IC Nurse B was asked if the resident returned on 4/24/24 why the Vantin wasn't started until 4/26/24 and IC Nurse B stated, they don't have Vantin in the back up medications. IC Nurse B was asked if Resident #18 received all 18 doses of the order Vantin and IC Nurse B stated the resident did. IC Nurse B was asked why the pharmacy didn't drop ship the Vantin so that the resident didn't go with out and IC Nurse B stated, we could have reached out to the pharmacy for a drop ship. IC Nurse B was asked what time on 4/24/24 did Resident #18 return to the facility and IC Nurse B opened up the nursing admission note which was time stamped 4/25/24 334 AM. IC Nurse B was asked to review the progress notes which revealed medication orders were placed on 4/24/24 at 10:30 PM. IC Nurse B was asked when the medication orders are normally placed and IC Nurse B offered, they are placed when the resident arrives. IC Nurse B was asked to clarify when the Vantin actually started and IC Nurse B stated, it appears she went all of 4/25 and am of 4/26 without the antibiotic. IC Nurse B was asked to provide a copy of every Infection Control Audit they do in the facility and staff education for perineal care (peri-care) for residents with recurrent UTI's. A review of the infection control reports along with IC Nurse B for Resident #18 revealed numerous and recurrent UTI's. On 6/5/24, at 11:30 AM, a record review of Infection Control Audits along with the Director of Nursing (DON) and IC Nurse B revealed no peri-care audits. The DON was asked how they could ensure the staff were doing peri-care correctly if they didn't audit them and the DON explained that the facility does do peri-care audits on the staff but didn't have documentation for them. Resident #39: On 6/04/24, at 1:00 PM, an observation of Resident #39 who was in their bed along with Nurse N was conducted. Nurse N donned the appropriate Personal Protective Equipment and exposed the urinary catheter tubing which was draped tight over their right thigh. There was a securement device to their right thigh which was soiled brown in color and appeared old. The catheter tubing was not secured inside the securement device. The urinary catheter tubing was soiled with brown substance. Nurse N was asked what they thought the brown substance was and Nurse N stated, it looks like BM (bowel movement). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/04/2024, at 2:45 PM, a record review of Resident #39's electronic medical record revealed an admission on 5/13/2024 with diagnoses that include stroke, retention of urine and urinary tract infection (UTI). Resident #39 required extensive assistance with Activities of Daily Living (ADL) and had intact cognition. A review of the care plan revealed I have altered urinary status r/t urinary retention Date Initiated: 05/07/2024 . Interventions Catheter care every shift and PRN . Ensure tubing is secured. Date Initiated: 05/13/2024 . On 6/05/24 3:24 PM, a review of the facility provided Catheter Care, Urinary Revision 5/2024 revealed . Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure Peripherally Inserted Central Catheter (PICC line - catheter inserted in the body through the arm that extends to the heart and is utilized for long term administration of intravenous [IV] medications) care was provided, per professional standards of practice and health care provider's order, for one resident (Resident #37) of one resident reviewed, resulting in a lack of dressing change completion, a lack of sterile technique during dressing change, resident verbalizations of concerns related to a lack of care, and the likelihood for infection and alteration in overall health status. Findings include: Resident #37: On 6/3/24 at 11:04 AM, Resident #37 was observed in their room, laying in bed. An IV pole with an empty bag of Meropenem (IV antibiotic medication) was present in the room. The medication bag was labeled for administration to Resident #37 but did not include the date/time the medication was hung and the IV tubing was not dated. A PICC line was present in Resident #37's Right Upper Extremity (RUE). The dressing on the PICC line was dated 5/24/24. An interview was completed at this time. When queried regarding their PICC line, Resident #37 stated, It's supposed to be changed and they ain't done it. With further inquiry, Resident #37 revealed they informed facility nursing staff it needed to be changed but they had not changed it. Record review revealed Resident #37 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included right ankle and foot osteomyelitis (bone infection), diabetes mellitus, kidney disease, and heart disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required set-up to substantial assistance to complete all Activities of Daily Living (ADL) with the exception of eating. The MDS further indicated the Resident was receiving IV medications. On 6/3/24 at 1:45 PM, Resident #37's IV was heard beeping from the hallway of the facility. Upon entering the room, Meropenem 500 milligrams (mg)/50 milliliters (mL) was hung and programmed to infuse at 100 mL/ hour via the beeping IV pump. The Resident's PICC line dressing remained dated 5/24/24. At 1:52 PM on 06/03/24, Licensed Practical Nurse (LPN) F entered the room to address the beeping IV infusion. The staff did not look at nor address the PICC line dressing. Review of Resident #37's Medication Administration Record (MAR) for June 2024 revealed documentation that the PICC line dressing had been changed on 6/2/24 by LPN U. Review of the Resident's EMR revealed the PICC line was replaced and the dressing was last changed on 5/24/24. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 2:30 PM, an interview was completed with the Director of Nursing (DON). When queried how frequently transparent PICC line dressings should be changed, the DON replied, Weekly. The DON was then asked to go to Resident #37's room with this Surveyor to observe the Resident's PICC line dressing. The DON entered the room and confirmed the PICC line was dated 5/24/24. The DON verbalized they would have a nurse change the dressing. When queried why the Resident's MAR included documentation that the dressing was changed by LPN U on 6/2/24, when the dressing was dated 5/24/24, the DON was unable to provide an explanation but stated they would address the concern. An observation of Resident #37's PICC line dressing change was completed on 6/3/24 at 3:03 PM with the Assistant Director of Nursing (ADON). During the sterile dressing change procedure, the ADON turned their back on the sterile field and the uncovered PICC line entry site two separate time allowing for contamination of the field and breaking sterile technique. Following the PICC line dressing change, an interview was completed with the ADON after exiting the Resident's room. When queried if PICC line dressing changes should be completed using sterile technique, the ADON confirmed they should. When asked if they should turn their back on their sterile field while completing a procedure requiring sterile technique, the ADON verbalized they should not and realized what they did incorrectly after they did it. Review of Resident #37's Electronic Medical Record (EMR) revealed a care plan entitled, I have a PICC line to RUE (Initiated and Revised: 5/11/24). The Care Plan included the intervention, Change IV dressing per order AND as needed for soiling or break in integrity (Initiated and Revised: 5/11/24). Review of Resident #37's Health Care Provider Orders revealed the following active orders: - Change IV dressing every day shift every Sun for PICC line Right Arm (Ordered: 5/21/24; Start Date: 5/26/24) - Change IV dressing as needed for soiling or break in integrity (Ordered and Start: 5/21/24) Review of facility policy/procedure entitled, PICC Placement and Maintenance (Reviewed: 3/30/24) revealed, 7. Dressings will be changed as follows: a. ANTT (Aseptic Non-Touch Technique) is adhered to when providing site care and dressing changes . b. The entire infusion system, including the VAD (Vascular Access Device)/CVAD (Central Vascular Access Device) will be routinely assessed for system integrity, infusion accuracy, identification of complications, and expiration dates of the infusate, dressing, and administration set. i. Transparent dressing changes will be done at minimum of every seven (7) days, or sooner if soiled, wet or nonocclusive . 10. Tubing changes are to be completed according to Infusion Nurses Society (INS) Standards a. Label administration sets with date of initiation, date of change due, time and initials

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 22347 This Citation pertains to Intake Number MI000144366. Based on observation, interview and record review, the facility failed to that ensure residents' food choices were honored, food was palatable (with temperature maintained), and an adequate amount of food was offered to one resident (Resident #47), and 4 of 4 residents in the Resident Council Meeting on 06/04/24 at 3:20 PM, resulting in anger, frustration and verbalizations of being hungry. Findings Include: Observation done on 6/3/24 at the noon meal revealed chili, a salad and beverages were served in the main dining room. The facility menu dated 6/3/24, revealed lunch was to include Texas toast. The resident's were not offered any toast, bread nor crackers to go with the chili. During an interview done on 6/3/24 at 1:50 p.m., Dietary Manager E stated (food company name given) makes our menu's; we follow the menu. They (resident's) didn't have bread or crackers today, it wasn't on the menu. The cook must of overlooked the toast today (Texas toast). We are getting tablets to take resident's orders. The Dietary Aide or the Aide will go to each room and ask what they want each day. We don't have a policy yet. We were approved two months ago to hire a dietary staff to do this; the hold-up is staffing; sometimes I am short and I can't afford to have someone out of the kitchen. Dietary Manager E revealed she has not hired anyone to implement the daily meal preferences, due to not having any time to hire someone. Resident #47: Review of the Face Sheet, diagnosis sheet and nursing notes dated 5/1/24 through 6/3/24, revealed Resident #47 was alert and able to make healthcare decisions. On 06/03/24 at 11:10 AM, during an interview, Resident #47 stated, Sometimes it's (facility food) cold and sometimes I just let them keep it, I can't eat some of that stuff. I told them I can't eat the oatmeal and they still sent it today (on 6/3/24 for breakfast meal), I can't eat that stuff. Sometimes it's not enough like the spoon of dried eggs, just a spoon of it. I have to try to eat it because there is nothing else. Sometimes it's cold and sometimes I just let them keep it; I can't eat some of that stuff. I told them I can't eat the oatmeal and they still sent it today (on 6/3/24), I can't eat that stuff. Sometimes it's not enough like the spoon of dried eggs, just a spoon of it. I have to try to eat it because there is nothing else. Observation revealed a white and blue alternative menu on the door of the room. Resident #47 denied being informed by staff about alternative foods available and that he could ask for more food, and he was not aware of the alternative menu in his room. Review of Resident #47's facility meal card (un-dated), stated dislikes oatmeal. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 6/3/24 at 12:38 p.m., Dietary Manager E stated, they (resident's) can ask for double portions when we do dietary assessments, and they have to ask for alternatives. We don't have a policy for portions. Dietary Manager E acknowledged Resident #47 should not of had oatmeal on his tray. Food Council Meeting: Review of the facility Food Council Minutes dated 11/9/23, stated Resident concerns about food portion. Resident Council: During Resident Council on 6/4/2024 at 3:20 PM, the four attendees were asked if they had any concerns with dietary. They shared the following with this writer: - If they consume meals in their room, they are 30 to 45 minutes late. - The food lacks flavor and more times than often they do not enjoy their meals. - Many times, the meals are not at their preferred temperature. - One resident stated the food proportions are small and when they request a 2nd helping, they are informed they are out of food (for that meal that was served). - It's not consistent if their meals will have the appropriate accompaniments. 37668 39059 On 6/04/24, at 12:34 PM, during lunch meal service, the kitchen was asked to provide a lunch meal for observation. The tray was passed from the serving line directly to the surveyor and walked to the conference room. The lunch tray consisted of two soft taco shells filled with shredded chicken and cheese. There was a small portion of lettuce with cut up tomatoes on top and one scoop of rice. There was one cup of lemonade, one small dish of tropical fruit, one set of silverware and one napkin. There was no salt, pepper, no taco sauce/salsa, no sour cream, and no dressing. The lemonade did not have ice in it and was not cold. The lemonade was checked for the temperature and resulted a Fahrenheit temperature of 60 degrees. The tropical fruit resulted a Fahrenheit temperature of 59 degrees. On 6/05/24, at 12:06 PM, DM E was asked to obtain a temperature of the next punch/lemonade provided. A tray was set down and the punch did not have ice cubes in it. DM E obtained a Fahrenheit temperature of the punch which resulted 57.4 degrees. On 6/05/24, at 12:53 PM, an observation along with DM E of the 300 hall tray cart revealed the cart door to be closed. There was a glass of punch on a lunch tray which now had ice cubes in it.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32000 Based on observation, interview, and record review the facility failed to maintain cold holding refrigeration temperatures of potentially hazardous food in the kitchen resulting in an increased potential for foodborne illness, potentially affecting the facility's total census of 79 residents who receive meal services. Findings include: On 6/4/24 at 11:47 AM, while observing lunch being plated from the kitchen's steam table, the surveyor observed the two door reach-in cooler located between the juice and coffee stations with both doors in the fully opened position. At this time the surveyor inquired with Dietary Manager, staff E, on if this was a normal practice during meal service to which they replied, yes. On 6/4/24 at 1:10 PM, upon review of the contents in the two door reach-in cooler the surveyor asked staff E, if they could take a temperature of the remaining portion of milk from the days lunch service to which they stated, of course. On 6/4/24 at 1:12 PM, temperature verification from staff E's thermometer probe revealed a temperature of 55 degrees F. At this time the surveyor inquired with staff E on what they would normally do when identifying a potentially hazardous food product at a temperature such as this they replied, we would put it in the trash. Review of 2017 U.S. Public Health Service Food Code, Chapter 3-501.16, Time/Temperature Control for Safety Food, Hot and Cold Holding directs that: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (2) At 5 C (41 F) or less. 39059 On 6/05/24, at 12:05 PM, Dietary Manager (DM) E was asked to enter the main dining room with their thermometer. Resident #30 was sitting at a table with two glasses of milk; one with sips taken. The temperature was checked of the full glass of milk and resulted a Fahrenheit temperature of 51.3 degrees. DM E offered to get Resident #30 another glass of milk and they denied. On 6/05/24, at 12:07 PM, DM E was asked to obtain a milk temperature of the next tray leaving the kitchen. A tray was provided directly from the tray line. The milk was checked for the Fahrenheit temperature which resulted 52.3 degrees. No new milk was provided to the residents in the dining room. On 6/05/24, at 12:13 PM, the Administrator was alerted of the milk temperature results of the milk provided in the dining room for lunch and the Administrator offered that they discard the milk after the four-hour time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/05/24, at 12:53 PM, an observation along with DM E of the 300 hall tray cart revealed the cart door to be closed. DM E was asked to obtain a Fahrenheit temperature of a glass of milk which resulted 48 degrees at the bottom of the glass and 47.5 degrees at the top of the glass. The glass of milk had ice cubes in it. DM E was asked if the kitchen staff was asked to place ice cubes into the milk glasses for lunch and DM E stated, yes and that sometimes they do. DM E was alerted of the complaints of warm milk and warm juices and DM E stated, I know what we have to do to fix it. DM E was asked if the fridge door being left open during meal service was the problem and DM E stated, yes and planned to now set up the drinks first thing in the am and place them in the walk in cooler prior to meal service. On 6/05/2024, at 1:56 PM, DM E was asked to provide the food temperature logs for the months of May and June, 24. On 6/05/24, at 2:56 PM, a record review of the temperature logs revealed May 27, 28 and 29, 2024 was not provided by the facility for review. The temperature logs reviewed did not have a column for the start time or the discard time for the milk served out of the kitchen and did not reveal any four-hour time frame of when the milk left the refrigerator and was to be discarded by the kitchen staff. The logs revealed that milk was not routinely checked for a serving temperature and revealed the following Milk temperatures: 5/1/2024 Supper . Food Serving Temp Start . Milk 52 5/2/2024 Lunch . Milk 50 5/4/2024 Supper . Milk 48 5/5/2024 Supper . Milk 44 5/8/2024 Lunch . Milk 50 5/9/2024 Supper . Milk 54 5/22/2024 Supper . Milk 44 5/23/2024 Supper . Milk 45 A review of the Food Preparation and Service Policy Revised April 2019 revealed Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices . Food Preparation, Cooking and Holding Time/Temperatures The danger zone for food temperatures is between 41F and 135F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. The longer the foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefor, PHF must be maintained below 41F .