STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235144	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte St L' Anse, MI 49946

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on observation, interview, and record review, the facility failed to ensure appropriate assessments, physician orders, risk education, medical justification, and care plans for restraints were in place for one Resident (R36) of one resident reviewed for restraints. Findings include: Resident #36 (R36) On 7/10/24 at 3:30 p.m., R36 was observed sitting in a wheelchair with a tray table in front of her. The tray table was attached to both sides of the wheelchair. The tray table extended across the width of the wheelchair, securing R36 in the wheelchair. R36 was unable to remove the tray table from the wheelchair. During the observation, R36 was also observed sitting on a pommel cushion (a cushion with a raised, center protuberance on the front of the cushion). The medical record revealed R36 was admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's Disease. A quarterly Minimum Data Set (MDS) Assessment completed on 5/7/24 documented R36 as having short-term and long-term memory impairment with severely impaired cognitive skills for daily decision making. The MDS did not code the use of physical restraints. The tray table was not documented in the care plan for R36. There were no physician's orders for a pommel cushion or tray table to the wheelchair. On 7/10/24 at 3:33 p.m., Certified Nursing Assistant (CNA) M was asked why R36 had a tray table across her wheelchair. CNA M said R36 used the wheelchair tray table during meals and the tray table was removed after meals. When asked how the tray table assisted with meals, CNA M shrugged her shoulders. When asked what time R36 had finished with the lunch meal, CNA M replied, I don't know. When asked what time the tray had been secured to the wheelchair, CNA M replied, I don't know. The Director of Nursing (DON) was interviewed on 7/10/24 at 3:50 p.m. The DON was asked about restraint assessments and resident representative consent for the use of the pommel cushion and wheelchair tray table. The DON said restraint assessments were completed by the Occupational Therapist (OT) or by the Physical Therapist Assistant (PTA). The DON said the OT and PTA were not at work, but the Administrator (NHA) was calling them to obtain the information. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 4:00 p.m. on 7/10/24, The DON provided an untitled, plain sheet of paper upon which was typed, To aid my mother with safety and positioning, it is my wish that we implement a tray on my mother's wheelchair. The sheet of paper contained the name of R36's daughter and was dated 4/9/24. The DON conveyed the sheet of paper was the Resident Representative consent. The DON was asked if the potential risks of the restraints had been conveyed to the Resident Representative. The DON said that information would be contained in the pending therapy documentation. The DON was asked why the wheelchair tray table was placed and she said to keep R36 from falling. The DON was asked what interventions had been attempted prior to applying the wheelchair tray table and the pommel cushion. The DON replied, nothing. The DON was asked if there was an assessment, consent, or order for the pommel cushion. The DON said she was waiting for the documentation from therapists. Physician documentation from December 2023 through June 2024 was reviewed. The physician did not document regarding a pommel cushion or wheelchair tray table for R36. On 7/11/24 at 9:34 a.m., the DON reported the OT and PTA did not have any information on the restraints for R36. The DON confirmed that prior to 7/10/24 there were no restraint assessments, no education to the resident representative on the risks of restraint usage, no physician's order to use the restraints, no documentation of the medical symptom for which the restraints were implemented, and no care plan for the wheelchair tray table. The policy Restraint Free Environment dated 6/21/23 read, in part: .'Physical Restraint' refers to .equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: .using devices in conjunction with a chair, such as trays .that the resident cannot remove . The facility is responsible for the appropriateness of the determination to use a restraint. 5. Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints .The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint .The facility shall explain to the resident/resident's representative, the potential risks and benefits of using a restraint, not using a restraint, and alternatives to restraint use. Potential negative outcomes should also be explained.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on interview and record review the facility failed to revise care plans after multiple falls for four Residents (#17, #26, #36, and #47) of fourteen residents reviewed for care planning. This deficient practice resulted in the potential for further falls and the potential for injury. Findings include: Resident #17 (R17) Review of R17's Minimum Data Set (MDS) assessment, dated 4/21/24, revealed admission to the facility on [DATE], with active diagnoses that included: unsteadiness on feet, schizophrenia, down syndrome, anxiety disorder, and depression. R17 scored a 99 on the Brief Interview for Mental Status (BIMS) reflective of an incomplete interview due to R17 not participating in the assessment or giving a nonsensical response. Review of the facility fall reports revealed R17 had two falls in January on 1/23/24 and 1/24/24, one fall in February on 2/16/24, and one fall in March on 3/2/24. The care plan for R17 was not revised after each fall. During an interview on 7/11/24 at 8:37 a.m., the Director of Nursing (DON) acknowledged revisions should occur after each fall. The DON stated, sometimes I don't have interventions to add to the care plan. R17's care plan revealed no revisions were made to R17's care plan after any of the four falls. R17's care plan was initiated on 2/22/24 and last revised on 2/26/24. Resident #47 (R47) Review of R47's MDS assessment, dated 6/13/24 revealed admission to the facility on [DATE], with active diagnoses that included: Parkinson's disease, hypertension, anemia, anxiety disorder, and depression. R47 scored a 15 of 15 on the BIMS reflective of intact cognition. Review of facility fall report revealed R47 had a fall on 7/3/24. The care plan for R47 was not revised after the fall. During an interview on 7/9/24 at 1:52 p.m., the DON said, Our care plans have been bad regarding person-centered care plans. During an interview on 7/11/24 at 8:37 a.m., the DON acknowledged care plan revisions should occur after each fall. The DON stated, Sometimes I don't have interventions to add to the care plan. R47's care plan revealed no revisions were made to R47's care plan after the fall on 7/3/24. R47's care plan was initiated on 3/28/24 and last revised on 4/9/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49310 Resident #26 On 7/9/24 at 9:00 a.m., Resident #26 (R26) was observed with a large area of bruising to the left eye. Registered Nurse (RN) B said, (R26) has had a lot of falls. RN B said R26 fell on [DATE] and was sent to the hospital for evaluation as a result of the fall. R26 had a primary diagnosis of Alzheimer's Disease. A BIMS examination dated 4/20/24 scored R26 as severely cognitively impaired. A quarterly MDS dated [DATE] documented R26 required moderate to maximal assistance from staff to complete Activities of Daily Living (ADL). The Falls care plan for R26 revealed the most recent intervention was initiated on 4/30/24. R26 experienced falls on 5/5/24, 5/11/24, 6/7/24, 6/17/24, 6/22/24, and 7/3/24. The care plan was not updated or revised with additional or amended interventions for any of the falls on those dates to minimize the risk of fall recurrence. Resident #36 Resident #36 (R36) was admitted to the facility with a primary diagnosis of Alzheimer's Disease. A quarterly MDS completed on 5/7/24 documented R36 with a BIMS score of 99 indicating R36 was unable to participate in the cognitive assessment. On 7/10/24 at 3:30 p.m., R36 was observed sitting in a wheelchair with a tray table in front of her. The tray table was attached to both sides of the wheelchair. The tray table extended across the width of the wheelchair, securing R36 in the wheelchair. The care plans for R36 did not include the use of a wheelchair tray table. The falls care plan contained only one intervention initiated on 2/26/24 for a pommel cushion to the wheelchair. R36 experienced falls on 2/24/24 and 4/8/24. During an interview on 7/10/24 at 4:00 p.m., the DON was asked why the wheelchair tray table was placed on the wheelchair of R36. The DON responded the tray table was used to prevent R36 from falling and was placed after R36 fell on [DATE]. When asked why the intervention for the fall on 4/8/24 was not added to the resident's care plan, the DON did not supply a response. The care plan history was reviewed with the DON who confirmed the wheelchair tray table was never added to the plan of care for R36. The policy Accidents and Supervision dated as revised 6/17/24 read in part: .Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: .3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions . Modification is the process of adjusting interventions as needed .Monitoring and modification process include: .b. Evaluating the effectiveness of interventions c. Modifying or replacing interventions as needed d. Evaluating the effectiveness of new interventions . The policy Fall Risk assessment dated as revised 6/17/24 read in part: .care plans will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident .5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on interview and record review, the facility failed to ensure collaboration and communication between the facility and hospice provider for one Resident (R56) of one resident reviewed for hospice services. Findings include: Resident #56 (R56) A family member of R56 was interviewed on 7/8/24 at 2:39 p.m. The family member said R56 was originally admitted to the facility for skilled therapy but was now in the facility for long-term care. The family member said R56 had a severe decline in health and was now receiving hospice services. R56 was admitted to the facility on [DATE]. A review of R56's physician orders did not reveal an order for hospice, and the care plans for R56 did not contain a care plan for hospice. Hospice visit notes and hospice documentation were not located in R56's medical record. A progress note on 6/28/24 read, in part: . (resident's family member) and resident have been discussing hospice services. contacted hospice. There were no other progress notes that mentioned hospice. A hospice visit schedule was not located in the medical record. The Director of Nursing (DON) was interviewed on 7/9/24 at 11:12 a.m. The DON confirmed R56 was receiving hospice services. The DON said the order for hospice, visit schedule, care plan for hospice, and hospice visit notes were in a binder at the nurses' station or in R56's room. The binder was obtained and reviewed with the DON. The binder did not contain a hospice order, schedule, care plan, or hospice documentation of assessments or visits. The DON said she would call the hospice representative for the paperwork. The DON was asked when the resident started hospice services. The DON replied, I'm not really sure - some time last week, maybe on the 2nd or 3rd [July 2024]. When asked how the facility correlated and coordinated plans of care with hospice, the DON did not provide a response. The DON agreed an order for hospice should be in the resident's medical record, and hospice documentation should be in the facility. The DON also conveyed the expectation for a hospice care plan in R56's medical record. Registered Nurse (RN) A was interviewed on 7/9/24 at 11:26 a.m. RN A confirmed she was a nurse manager. RN A said she contacted hospice for documentation and a care plan. RN A said she was told by hospice they would send a care plan, but the care plan was not signed by a physician. When asked how staff know the days and times of hospice visits, RN A said, They [hospice] call the day they are coming in and I put it on the staffing sheet for the day. Staffing sheets for 7/1/24 - 7/9/24 were reviewed. There was no documentation on the staffing sheets regarding hospice employees scheduled to visit R56. On 7/9/24 at 11:40 a.m., RN A said hospice called the facility and said they would visit twice a week and the schedule had been entered into the shower book. When asked when R56 went on hospice services, RN A replied, I'm not really sure. RN A was asked if there should be an order for hospice and the reply was yes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice documentation was received and reviewed on 7/9/24 at 12:28 p.m. The documentation indicated R56 started hospice services on 7/2/24. The documentation included notes from RN's (Registered Nurses) dated 7/2/24 and 7/6/24, social worker documentation on 7/2/24, and Certified Nursing Assistant (CNA) documentation on 7/2/24 and 7/5/24. The hospice certification and plan of care did not contain the physician signature or date. The policy Coordination of Hospice Services dated 6/17/24 read, in part: Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being .The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs .The care plan will identify the care and services that each entity will provide in order to meet the needs of the resident .The facility will maintain communication with hospice as it relates to the resident's plan of care and series to ensure each entity is aware of their responsibilities .

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to ensure physician visits accurately reviewed the total program of care for four Residents (R24, R26, R36, & R38) of four residents reviewed for physician visits. This deficient practice resulted in the potential for lack of comprehensive and supervised medical care. Findings include: Resident #24 (R24) Review of R24's Admission Record revealed R24 was admitted to the facility on [DATE] with diagnoses that included the following, in part: Alzheimer's disease, diabetes, hallucinations, psychotic disorder with delusions, depression and generalized anxiety disorder. Review of R24's Physician Order Summary, retrieved 7/11/2024, revealed R24 was prescribed the following, in part: melatonin 3 mg (milligrams) at bedtime and memantine HCL (hydrochloride) 10 mg related to Alzheimer's disease, quetiapine fumarate 25 mg related to psychotic disorder with delusions, and sertraline HCL 75 mg related to depression, Review a comprehensive list of R24's medications which had been discontinued or completed, provided by the facility on 7/10/24 by the Director of Nursing (DON), revealed R24 was last prescribed Lorazepam on 10/5/23, which was completed on 10/19/23. Lorazepam was not prescribed by a physician order by R24's Physician (K) since 10/19/23 per the Electronic Medical Record (EMR) physician order report. Review of R24's Physician Visit notes, dictated by Physician K in the last six months revealed the following monthly documentation: Date: 12/21/2023: Subjective: Patient is on LOA (leave of absence/out of the facility) but I end up seeing her at the [Local Restaurant] all the time. She is doing fine. Her husband is doing fine. No problems. Plan: She is on 25 of Seroquel bid for the psychotic features of her advancing Alzheimer's as well as 75 for depression. She also needs 0.5 of Ativan p.r.n. (as needed-sic) for when she gets agitated, and she really does get agitated and violent. Signed by Physician K. (Entirety of Physician Visit Note) Date: 01/25/24 . Plan: Continue Seroquel (quetiapine fumarate) 24 mg twice a day, Zoloft 75 mg daily, and Ativan 0.5 mg every 12 hours as needed . Dictated by Physician K. Date: 02/22/24 .Plan: Continue current management . Ativan 0.5 mg every 12 hours as needed for 14 days for her agitation and hallucinations . Dictated by Physician K. Date: 03/24/24 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subjective: Patient is on LOA (leave of absence/out of the facility) with husband, doing well. Taking Seroquel 25 b.i.d. (twice daily) from (sic) her dementia, 75 daily for depression, Ativan 0.5 mg every 12 hours p.r.n. (as needed) for another 14 days. Dictated by Physician K. This entry was the entirety of the physician visit note for March 2024. Date: 04/25/2024 Subjective: The patient was on leave (out of the facility). Assessment/Plan: [R24] is on Seroquel 25 mg twice a day for psychosis from her Alzheimer's, 75 mg daily for depression from Alzheimer's, and as needed Ativan 0.5 mg every 12 hours for her anxiety from her Alzheimer's. Signed by Physician K. This was the entirety of the physician visit note for April 2024. Date: 05/23/2024 Subjective: Patient has no complaints. Objective: (blank) Vital Signs: Vital Signs are stable. Patient is afebrile. Assessment: Advanced probable Alzheimer's disease. Plan: Continue Seroquel 25 b.i.d. for psychosis, 75 of Zoloft daily for depression, and Ativan 0.5 every 12 hours p.r.n. for her anxiety and panic attacks. (Entirety of Physician Visit May 2024 documentation) Date: 06/20/2024 Subjective: The patient is doing well. Husband has no concerns. (Husband is not the activated Durable Power of Attorney (DPOA) for Care as documented on the Admission Record retrieved on 7/8/24 at 2:57 p.m.) Plan: Continue current management. I will see her back for monthly rounds later. Dictated by Physician K. (Entirety of Physician Visit note) Date: 06/27/2024 Subjective: The patient was sleeping comfortably. Her crying out is minimal at this point. She is doing well. Plan: Continue the Xanax 0.25 mg twice a day for anxiety, Paxil 30 mg for anxiety and depression, Cymbalta 30 mg for anxiety and depression, and Risperdal (antipsychotic medication) twice a day for her dementia with psychosis. Dictated by Physician K on 6/27/24. (Entirety of Physician Visit note) (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/24 at 8:31 a.m., Health Information Coordinator (HIC) V was asked about the adequacy of Physician K's 12/21/23 Physician Visit Note which was documented although Resident R24 was not present in the building. HIC V stated, They (physician visit notes) leave something to be desired. We get notes like that all the time. He (Physician K) will write up a note saying the patient was sleeping . It is not unusual for [Physician K] to do dictation on sleeping residents . During an interview on 7/11/24 at 8:43 a.m., Physician K was provided a copy of R24's 6/27/24 Physician Visit Note for their review. When asked if the medications detailed in Physician K's dictation were accurate, and prescribed for R24, Physician K stated, I presume those are her medications, but I don't know. Normally I would not dictate anything about their medications on a progress note. When asked about completion of physician visits notes on residents not in the facility or sleeping residents, Physician K stated, Oh no, I don't dictate and do a visit on a sleeping resident. If they are LOA, I usually say they are LOA and do not do a visit. When asked completion of a comprehensive review of systems and medications on physician visits, Physician K stated, I don't go into the computer (Electronic Medical Record). I sign things all the time. I don't know exactly what I sign. When asked about the continuation of Ativan in their physician visit notes from 12/2023 through 5/2024 when the Ativan had been discontinued in October of 2023, Physician K stated, When they give me the (physician) orders (of resident's medications) I sign them. I don't have time to audit them (to ensure their accuracy). Physician K was unaware that the medications identified in R24's June 2024 Physician Visit Note were medications that were not prescribed to her, but those of another facility resident. Physician K said the facility provided the medication information and he went by their information. When asked if he was responsible for the accuracy of information that he dictated into the medical record, Physician K did not respond. Resident R26 Review of R26's Admission Record, retrieved 7/11/24 at 9:18 a.m., revealed R26 was admitted to the facility on [DATE] with diagnoses that included the following, in part: Alzheimer's disease, dementia with psychotic disturbance, major depressive disorder, anxiety disorder, and blindness of the left eye. R26 had an activated DPOA for both Care and Financial concerns. Review of Resident R26's Physician Visit Notes completed by Physician K in the last six months revealed the following, in part: Date: 12/21/2023 Subjective: Patient doing well. No complaints. Objective: Vital signs are stable. Patient is afebrile. Heart Regular. Lungs are clear. Assessment: Dementia, end stage with psychosis, depression, and anxiety. Plan: Continue the Xanax 0.25 b.i.d. the Paxil 30, the Cymbalta 30, and Risperdal 0.5 b.i.d. (Entirety of Physician Visit Note) Date: 01/252024 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subjective: Patient was sleeping. Patient doing well. On Xanax 0.25 b.i.d., Paxil 30, Cymbalta 30 for depression, dementia, and anxiety. Risperdal 0.5 b.i.d. for psychosis or dementia. She is doing well on these, and GDR (Gradual Dose Reduction) is contraindicated. Dictated by Physician K. (Entirety of Physician Visit Note) Date: 2/22/24 Subjective: The patient is getting bathed. She is doing well by report. Plan: Xanax 0.25 mg twice a day for anxiety as needed, Paxil 30 mg daily, and Cymbalta 30 mg for depression, and Risperdal 0.5 mg twice a day for psychosis she gets with her dementia. Dictated by Physician K. (Entirety of Physician Visit Note) Date 03/28/24 Subjective: The patient is sleeping. No complaints reported. Objective: The patient is resting comfortably. Assessment: 1. Depression, 2. Dementia with psychotic features. Plan: Continue Xanax 0.25 mg twice a day for anxiety, Paxil 30 mg daily for depression and anxiety. Cymbalta 30 mg daily for anxiety and depression, and Risperdal 0.5 mg twice daily for psychotic features and dementia. Dictated by Physician K. (Entirety of Physician Visit Note) Date: 4/25/24 Subjective: Apparently, she has been complaining about some back pain lately and has been rather restless. Objective: Vital Signs: Vital signs are stable. Patient is afebrile. Heart: Regular. Lungs: Clear. Assessment: Dementia with psychotic features, as well as having some back pain. Plan: Decrease her Risperdal to 1.5 b.i.d. She has been falling a bit, and instead will try her on 7.5 daily of Mobic. Continue the Xanax 0.25 b.i.d. for anxiety, the Paxil 30 daily, and Cymbalta 30 daily for depression. Risperdal 2 b.i.d. for dementia or the psychosis. Dictated by Physician K. (Entirety of Physician Visit Note) Review of all Physician Visit Notes in R26's EMR found no visits documented after 4/25/24. Review of R26's Physician Order Summary, retrieved 7/11/24 at 9:21 a.m., revealed R26 was prescribed Risperidone (Risperdal) 3 mg by mouth two times a day related to unspecified dementia, unspecified severity, with psychotic disturbance starting 6/20/24. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/24 at 8:50 a.m., HIC V was asked about lack of physician visit documentation for R26 since 4/25/24. HIC V stated, I was just looking and that and I am going to call up there - to the Hospital Physician Practice - to see if there is a physician progress note we have not received yet. I think a visit must have been done but we just don't have the physician progress note yet. During an interview on 07/11/24 at 9:44 a.m., HIC V reviewed the list of Physician Visits Due on his computer in the presence of this Surveyor. The list showed R26 was due for a physician visit on 6/24/24. No documentation was present in the chart showing a visit had been completed. During an interview on 7/11/24 at 10:00 a.m., HIC V confirmed no Physician Visit Note for R26, from Physician K, was available for a visit in June of 2024. Resident R36 Review of R36's Admission Record, retrieved 7/10/24 at 3:43 p.m., revealed R36 was admitted to the facility on [DATE], with diagnoses that included the following, in part: Alzheimer's disease, depressive disorder, anxiety disorder, muscle weakness (5/6/24 onset date), unsteadiness on feet (5/6/24 onset date), and other abnormalities of gait and mobility (5/6/24 onset date). R36 had an activated DPOA for both Care and Financial concerns. Review of R36's Physician Order Summary, retrieved 7/10/24 at 3:44 p.m., revealed the following medications as currently prescribed to R36: acetaminophen, Aquaphor ointment, aspirin, bisacodyl laxative suppository, Lasix (diuretic), melatonin (sleep aid), Milk of Magnesia (for constipation), nystatin (for rash), Risperdal 0.5 mg two times a day (for anxiety), and sertraline HCL (for depression). Diagnoses listed on the Physician Order Summary included the following: edema, arthritis, uterovaginal prolapse, major depressive disorder severe with psychotic symptoms, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, dysphagia, Alzheimer's disease, and anxiety disorder. No diagnosis of chronic obstructive pulmonary disease was present on the Physician Order Summary, nor was it listed on R36's Admission Record. Review of R36's Physician Visit Notes, dictated by Physician K in the last six months revealed the following: Date: 12/21/23 Subjective: Patient Sleeping comfortably, no complaints. Objective: Vital Signs: Vital signs are stable. Patient is afebrile. General: Patient is not agitated and sleeping comfortably. Assessment: Dementia, probably Alzheimer's type. Plan: Continue current management. She is on Zoloft 50 daily for depression and Risperdal 0.5 mg b.i.d. for anxiety and psychotic features of her dementia. Dictated b Physician K. (Entirety of Physician Visit Note) (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date: 1/25/24 Subjective: The patient is awake and joking. No complaints. Objective: Vita signs stable. The patient is afebrile. Heart is regular. Lungs are clear. Sensorium is rather clear for her today. She was describing us as pain. Assessment: End-stage dementia with depression and anxiety. Plan: 1. Continue current management. She is doing well. 2. Continue with Zoloft 50 mg daily and Risperdal 25 mg twice a day for anxiety and depression. It is contraindicated to adjust her dosages given the severity of her dementia. Dictated by Physician K. (Entirety of Physician Visit Note) Review of Risperdal Dosage per Drugs.com, last updated 8/31/2022, revealed the following, in part: Efficacy (of Risperdal dosage) has been demonstrated in a range of 4 mg to 16 mg per day. However, doses above 6 mg per day for twice daily dosing were not demonstrated to be more efficacious than lower doses, were associated with more extrapyramidal symptoms and other adverse effects, and are generally not recommended . Date: 02/22/2024 Subjective: The patient has no complaints today. Objective: Vital signs stable. The patient is afebrile. Heart is regular. Lungs are clear. Assessment: 1. Dementia, probably Alzheimer's, end stage. 2. COPD (chronic obstructive pulmonary disease). Plan: 1. Continue current management. 2. Continue the Zoloft 50 mg daily for depression and Risperdal twice a day 0.5 mg for anxiety and hallucination. Dictated by Physician K on 2/22/24 at 9:20 a.m. (Entirety of Physician Visit Note) Date: 03/28/2024 Subjective: Patient sleeping comfortably. Objective: Patient sleeping comfortably, not distressed at all. Assessment: Depression and advanced dementia. Plan: Continue the Zoloft 50 for the depression, and Risperdal 0.5 b.i.d. for agitation and hallucinations. Dictated by Physician K on 3/2824 at 10:20 a.m. (Entirety of Physician Visit Note) Date: 04/25/2024 Subjective: The patient is doing well, no complaints. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Objective: Vital signs stable. The patient is afebrile. Heart is regular. Lungs had an occasional expiratory wheeze, but she has severe COPD in addition to her dementia. Assessment: Dementia, probably Alzheimer's. Plan: Zoloft 50 mg for depression and Risperdal 0.5 mg twice a day for anxiety and hallucinations from her dementia. Dictated by Physician K on 4/25/24 at 9:40 a.m. (Entirety of Physician Visit Note) Date: 05/23/2024 Subjective: The patient is doing well, did not want to talk to me today. This is usual for her. Objective: Vital signs stable. The patient is afebrile. Heart is regular. Lungs have occasional expiratory wheeze. She has end-stage COPD as well. Assessment: Dementia, end stage. Plan: Continue Zoloft 50 mg for depression and risperidone 0.5 mg twice a day for anxiety and psychosis. Dictated by Physician K on 5/23/24 at 11:30 a.m. (Entirety of Physician Visit Note) Date: 6/27/24 Subjective: No complaints. Objective: Vital signs stale. The patient is afebrile. Heart is regular. Lungs clear. Assessment: Dementia with anxiety and hallucinations. Plan: Continue the Zoloft 50 mg daily for depression and the Risperdal 0.5 mg twice a day for anxiety and psychosis. Dictated by Physician K on 6/27/24 at 9:20 a.m. (Entirety of Physician Visit Note) Resident R38 Review of R38's Admission Record, retrieved 7/10/24 at 3:19 p.m., revealed R38 was admitted to the facility on [DATE] with diagnoses that included the following, in part: Parkinson's disease, dysphagia, erosive osteoarthritis, depression, pressure ulcer of sacral region, scoliosis, and pain in thoracic spine. R38 did not have an activated DPOA and was responsible for their own decisions. Review of R38's Physician Order Summary ,retrieved 7/10/24 at 3:20 p.m., revealed R38 was prescribed the following medications: acetaminophen, bisacodyl laxative suppository, Carbidopa-Levodopa Oral Tablet 25-100 (for Parkinson's disease), docusate sodium (for bowel management,) Effexor XR (extended release) 150 mg (for depression), Eliquis 5 mg (for cardiomyopathy), Entacapone 200 mg (for Parkinson's disease), ferrous sulfate (iron supplement), Lidocaine (pain management for wound treatments), Milk of Magnesia (for constipation), multivitamin, Rotigotine patch (for Parkison's), polyethylene glycol (for constipation), Simvastatin (for high cholesterol), and Vitamin D. R38 had physician orders for pressure ulcer wound treatment beginning 11/28/23 which read: Skin, Pressure Ulcer & Wound treatment Protocol - May follow facility protocol. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R38's Physician Visit Notes for the last six months, completed by Physician K, revealed the following: Date: 12/02/2023 (Admission Assessment) Chief Complaint: Inability to perform ADLs (activities of daily living) at home due to Parkinson's disease. History of Present Illness: The patient is an [age and gender] who presents from [acute care hospital) for residential care seeing how she is unable to perform ADLS due to her Parkinson's disease. The patient otherwise is well. Has not complaints but staff has noted a mass [R38's] right anterior shoulder on admission last week . Past Medical History: Significant for . Parkinsonism . Stage 2 bedsore on the sacral region . Dictated by Physician K on 12/7/24 at 9:05 a.m. Date: 12/21/2023 Subjective: Patient is doing well today. Has no complaints. Wanted to chat a bit. Objective: Vital signs are stable. Patient is afebrile. Heart regular. Lungs are clear. Affect is fairly bright. Assessment: Dementia with depressive signs. Plan: Continue the 75 of Effexor daily for depression. Patient is getting over COVID and doing relatively well. Dictated by Physician K on 12/21/23 at 10:55 a.m., (Entirety of Physician Visit Note). Date: 02/22/2024 Subjective: Patient has no complaints today, doing well. Objective: Vital signs: Vital signs are stable. Patient is afebrile. Heart: Regular, Lungs: Clear. Assessment: Dementia end-stage. Plan: Patient's medical determination has been signed off on. For her depression she is taking Effexor 75 daily in the morning. Dictated by Physician K on 2/22/24 at 10:10 a.m. (Entirety of Physician Visit Note) Review of R38's Progress Notes, revealed a Physician Visit was completed on 2/23/24, by Physician W, for the purpose of capacity evaluation (capacity to make her own medical decisions) which read, in part: . she notes that she has scoliosis and example of identifying her own medical problems. Causes daily pain especially in her lumbar spine, she asked for medication for this. We discussed that this is not the point of interview, and I will talk to [Physician K] about possible pain medications .She is able to clearly identify medical problems, articulated choice, evaluate that choice and provide rationale to support her decision. Presently, she supports positive capacity evaluation and should remain able to make her medical decisions. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Date: 03/28/2024 Subjective: No complaints. Objective: Vital Signs: Vital signs are stable. The patient is afebrile. Heart: Regular. Lungs: Lungs are clear. Assessment: 1. Parkinsonism with dementia. 2. Depression. Plan: continue the Effexor 75 for the depression. Dictated by Physician K on 3/28/24 at 10:53 a.m. (Entirety of Physician Visit Note) Date: 4/25/2024 Subjective: Patient doing well, no complaints. Objective: Vital Signs: Vital signs are stable. Patient is afebrile. Heart: Regular. Lungs: Clear. Assessment: Dementia, probably Alzheimer's with some depression. Plan: Continue Effexor 75 daily. Dictated by Physician K on 4/25/24 at 10:40 a.m. (Entirety of Physician Visit Note) Date: 05/23/2024 Subjective: The patient has no complaints. Objective: Vital signs stable. The patient is afebrile. Heart is regular. Lungs are clear. Assessment: Dementia with depressed features, severe. Plan: Continue Effexor 75 mg daily for control of her depression. Dictated by Physician K on 5/23/24 at 11:35 a.m. (Entirety of Physician Visit Note) Date: 06/27/2024 Subjective: Patient was sleeping comfortably. Continue the Effexor 75 for her depression. She is allowed 1 alcoholic beverage per day. Dictated 6/27/24 at 10:00 a.m. (Entirety of Physician Visit Note) Review of R38's above Physician Visit Notes completed by Physician K changed R38 from a Resident admitted with Parkinson's disease to being documented as having dementia with depressive signs on the 12/21/23 physician visit. Resident R38 was documented in the Admission Physician Visit Notes, by Physician K with a stage two bedsore on her sacral region. No further reference was made in the next six months of Physician Visit Notes, dictated by Physician K, to document healing or worsening of R38's pressure injury, although treatments continued at the time of the recertification survey. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24 at approximately 7:30 a.m., the Nursing Home Administrator (NHA) was informed of this Surveyor's concerns with review of the Physician Visit documentation, completed by Physician K that did not include a comprehensive review of systems of medications for facility residents. The NHA expressed understanding of the concern and acknowledged she had spoken with Physician K in the past regarding concerns with their physician visit documentation. Review of the Physician Visits and Physician Delegation Policy, implemented 6/15/24, revealed the following, in part: It is the policy of this facility to ensure the physician takes an active role in supervising residents . The Physician should: a. See resident within 30 days of initial admission to the facility. b. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by physician or physician delegate as appropriate by State Law. c. Review the resident's total program of care including medications and treatments at each visit. d. Date, write and sign a progress note for each visit . 4. The Medical Director should: a. Visit residents who are not seen by their attending physician or alternate physician according to schedule. b. Document a progress note and orders for care as needed. c. Notify the attending physician and family of the results of the visit .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on interview and record review, the facility failed to ensure adequate numbers of staff to meet the needs of four (Residents #47, #7, #15, and #24) of fifty-seven residents sampled for sufficient staffing and three [Resident #C1 (C1), Resident #C4 (C4), and Resident #C7 (C7)] of seven residents from a confidential resident council meeting. This deficient practice resulted in the potential for a decline in resident quality of life and/or quality of care, not receiving medications timely, and unmet care needs for all fifty-seven residents. Findings include: Resident #47 (R47) Review of R47's Minimum Data Set (MDS) assessment dated [DATE] revealed admission to the facility on [DATE], with active diagnoses that included: Parkinson's disease, hypertension, anemia, anxiety disorder, and depression. R47 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) assessment, reflective of intact cognition. During an interview on 7/9/24 at 8:34 a.m., R47 stated I fell last week when I tried to move, and there were not enough staff to help. It happened in the evening. around 7:30. I was on the floor for quite some time. Resident #7 (R7) Review of R7's MDS assessment dated [DATE] revealed admission to facility on 2/13/24 with active diagnoses that included: hypertension, and renal (kidney) insufficiency/renal failure/or end stage renal disease. R7 scored 15 of 15 on the BIMS reflective of intact cognition. During an interview on 7/8/24 at 2:31 p.m., R7 stated the facility is short staffed of nurses and aides. R7 said it sometimes takes 3 hours before R7 receives PRN (as needed) meds (medications) or before R7's call light is answered. R7 said meds are not given timely. Resident #15 (R15) Review of R15's MDS assessment dated [DATE] revealed admission to facility on 3/5/24 with active diagnoses that included: depression, heart failure, hypertension, and diabetes mellitus. R15 scored 15 of 15 on the BIMS reflective of intact cognition. During an interview on 7/8/24 at 2:22 p.m., R15 stated It takes about a half an hour to have someone answer your call light. They do not have enough people to work. Resident #24 (R24) Review of R24's MDS assessment dated [DATE] revealed admission to facility 7/26/23, with active diagnoses that included: cancer, hypertension, diabetes mellitus, anxiety, depression, and Alzheimer's disease. R24 scored 4 of 15 on the BIMS assessment, reflective of severe cognitive impairment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/8/24 at 2:15 p.m., the resident representative (RR) for R24 was queried if the facility had enough staff. RR stated, You know the answer to that. No, they don't have enough staff. During an interview on 7/10/24 at 9:59 a.m. with the Director of Nursing (DON) and the Nursing Home Administrator (NHA), the NHA acknowledged there are 11 positions open currently in nursing. During an interview on 7/10/24 10:18 a.m., Licensed Practical Nurse (LPN) H stated there is not sufficient staffing for residents between 3 pm and 11 pm and it probably happens a handful of times a week. During an interview on 7/10/24 at 10:23 a.m., Certified Nursing Assistant (CNA) L stated, Staffing is not the greatest. Sometimes we have a hard time. We just need more staff. The staffing on the weekends is horrible, we have to leave people in bed so that helps but we cut corners. During an interview on 7/10/24 at 10:39 a.m., CNA M stated, Staffing is short, we are short on night shift more than day shift, but it does happen on both shifts. There is one weekend that is normally bad and then one that is ok, this upcoming weekend is usually the tough one. We work short. When we are short staffed we don't do all the things we need to do. During a confidential group meeting on 7/9/24 at 11:00 a.m., C7 stated It does take a long time to answer lights in a timely manner. They are short staffed. There is only one staff on nights sometimes. C1 and C4 agreed that the facility is short staffed and call lights are not answered timely. Review of the Facility Assessment (FA) on 7/10/24 at 8:00 a.m., revealed the facility will schedule 4-5 CNA's on day shift, the facility will schedule 4-5 CNA's on afternoon shift and the facility will schedule 2 CNA's on night shift. Upon review of staffing assignments, the facility only scheduled 3 CNA's from 7 pm-11 pm on 2/11/24, 2/18,24, 2/24,24, 2/25/24, 3/2/24, 3/3/24, 3/9/24, 3/10/24, 3/16/24, 3/23/24, 3/24/24, 3/30/24, and 3/31/24. During an interview on 7/11/24 at 8:24 a.m., the NHA acknowledged 3 CNA's were scheduled from 7 pm to 11 pm which contradicted how many CNA's are needed according to the Facility Assessment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49735 Based on interview and record review, the facility failed to ensure three Certified Nurse Aides (CNA) [P, S, and T] had the required yearly competency trainings, including demonstration in skills and techniques necessary to care for Residents. This deficient practice has the potential for staff to lack the necessary training to adequately meet the needs of all 57 residents that reside in the facility. Findings include: A review of facility staff personnel records revealed CNA P was hired 2/25/22. CNA P's personnel record did not demonstrate dated competency skills since date of hire. A review of facility personnel records revealed CNA S was hired 4/13/21. CNA S's personnel record did not demonstrate dated competency skills after date of hire. A review of facility personnel records revealed CNA T as hired 5/27/23. CNA T's personnel record did not demonstrate dated competency skills after date of hire. During an interview on 7/11/24 at 08:24 a.m., the Director of Nursing (DON) and Nursing Home Administrator (NHA) acknowledged there were undated competency skills for staff. The DON stated, we should have had a date on our skills training. Review of Facility Assessment (FA) last revised 8/8/23 . read in part, employees are competency evaluated annually on . 23 areas regarding resident care and facility duties. This surveyor did not receive a checklist of the 23 areas listed in the Facility Assessment. The facility presented an incomplete and undated list of training on 13 areas the DON referenced as the staff's competency training.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 49735 Based on interview and record review, the facility failed to complete performance reviews for three of three Certified Nurse Aides (CNA's) [P, S, and T] at least once every 12 months. This deficient practice resulted in the potential for inadequate care and unmet resident care needs for all 57 residents living in the facility. Findings include: Review of facility personnel records demonstrated that CNA S was hired on 4/13/21 with no annual performance review. CNA T was hired on 5/27/23 with no annual performance review. CNA P was hired on 2/25/22 with no annual performance review. During an interview on 7/10/24 at 12:49 p.m., the Director of Nursing (DON) acknowledged no performance reviews had been completed in the past year. During an interview on 7/10/24 at approximately 1:30 p.m., the Human Resource staff O stated No performance reviews have been completed since 2022. Review of facility policy titled Nurse Aide Training Program implemented on 4/11/24 . read in part, a review of the employee's .records shall be performed at least annually, such as at time of performance review. During an interview on 7/11/24 at 8:37 a.m., the Nursing Home Administrator (NHA) and DON both acknowledged performance reviews had not been completed.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735 Based on observation, interview and record review, the facility failed to provide adequate medically related social services to one Resident #15 (R15) of one resident reviewed for social services care. This deficient practice resulted in a lack of supportive visits, delayed referral to a behavioral care provider, and psychosocial decline. Findings include: Resident #15 (R15) Review of R15's Minimum Data Set (MDS) assessment, dated [DATE], revealed admission to the facility on [DATE], with active diagnoses that included: depression, heart failure, hypertension, and diabetes mellitus. R15 scored a 15 of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition. During an interview on [DATE] at 2:35 p.m., R15 stated sometimes I miss my son . he passed away and I get depressed. He had cerebral palsy and I took care of him for most of his life . I couldn't be with him when he died . R15 was teary eyed and stated he passed away this past October .but the staff or social worker does not talk with me about it. During an interview on [DATE] at 12:10 p.m., Social Services Designee (SSD) N acknowledged there were no supportive services, outside services, or emotional support given to R15 regarding the loss of R15's son. SSD N stated I did not talk with R15 about grief counseling .R15's diagnosis of depression . I did not offer outside agency support to R15 to deal with the loss of R15's son. SSD N stated I did not put anything into R15's care plan regarding the loss of R15's son. During an interview on [DATE] at 8:37 a.m., the Nursing Home Administrator (NHA) acknowledged SSD N did not address the loss of R15's son, SSD N did not implement a care plan regarding the loss of R15's son, SSD N did not offer R15 support for loss of son, and SSD N did not offer outside services with the most recent assessment on [DATE]. Review of facility policy titled Social Services date implemented [DATE], read in part, the facility .will provide medically related social services to each resident, to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being . social service designee will complete . a quarterly assessment, identifying any need for medically relate social services of the residents.Services to meet the residents needs may include . making referrals and obtaining needed services from outside entities . providing or arranging for needed mental and psychosocial counseling services . meeting the needs of residents who are grieving from losses . the facility should provide social services or obtain needed services from outside entities during situation that include . difficulty coping with change or loss .of a loved one, need for emotional support .the residents plan of care will reflect any .social service needs, and how these need are being addressed.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to ensure the timely reorder and acquisition of pressure ulcer wound treatment medication for one Resident (R51) of one resident reviewed for pressure ulcer treatment medication availability. This deficient practice resulted in the lack of prescribed medication and the potential for worsening of pressure ulcers for R51. Findings include: Review of R51's Admission Record, acquired 7/8/24 at 3:23 p.m., revealed R51 was admitted to the facility on [DATE], with a readmission on 12/4/23. Diagnoses included the following, in part: Partial traumatic amputation of right great toe, present on admission. Review of R51's Electronic Medical Record (EMR) on 7/9/24 at 8:23 a.m., revealed the following physician orders that required Santyl for the prescribed wound dressing medication in the Treatment Administration Record (TAR). 1. #23 Left Heel: Clean wound bed with Dial soap and pat dry. Apply nickel thick Santyl to wound bed and cover with Tegaderm High performance circular dressing . Start Date 5/8/24 0700 (7:00 a.m.) 2. Cleanse middle toe on left foot nail area with dial soap and NS (normal saline), or wound cleanser. Dr. Apply nickel thick Santyl to wound bed. Apply 4x4 gauze. Then attach tegrederm (sic) tape to secure. Change daily. Every day shift for Wound care. Start Date: 6/21/24 0700 (7:00 a.m.) 3. Left posterior calf. Wash with soap and water. Apply nickel thick Santyl to wound bed then apply 4x4 adhesive foam dressing. Every day shift for Wound care. Start Date: 6/26/25 0700 (7:00 a.m.) 4. Wound #18, surgical, right foot, toes. Clean wound bed with dial soap and water. Apply nickel thick Santyl to wound bed. Apply skin prep to peri (area surrounding)- wound and cover with a superabsorb or foam dressing. Daily and prn (as needed) until healed. Every day shift for Wound care. Start Date: 6/21/24 0700 (7:00 a.m.) Review of R51's TAR revealed wound treatment orders and accompanying progress notes for R51 beginning 7/3/24, that documented the unavailability of Santyl for treatment of R51's wounds. During an interview and observation on 7/09/24 at 8:30 a.m., when asked about the unavailability of the Santyl (cream) to complete the physician orders for R51's pressure injuries RN B said the Santyl came from a pharmacy in Chicago. RN B was not aware of why there was none currently available for R51's wound treatments. RN B opened the 100- hall medication cart in the presence of this Surveyor and confirmed no Santyl was available for R51's wounds at that time. RN B said the Santyl was supposed to be auto shipped, but they still didn't have Santyl. When asked why there was no Santyl documented on the TAR beginning on July 3rd, RN B had no explanation. RN B said she had not worked on the 100-hall for about a week, and the last time she worked Santyl was available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/09/24 at 10:35 a.m., when asked about the lack of Santyl (Wound debridement medication) beginning on 7/3/24 for R51's pressure injury treatment orders, the Director of Nursing (DON) said Registered Nurse (RN)/Unit Manager A was informed the previous day (7/8/24) that no Santyl was available in the medication cart for R51. RN A contacted [pharmacy name] to ensure delivery of Santyl. During this interview, the DON received a call from [pharmacy name] which informed her that the delivery of Santyl could not be delivered by 7/10/24 at noon. The DON was asked to review R51's progress notes and confirmed beginning on 7/3/24 progress note documentation showed Santyl was not available in the medication cart. The DON reviewed the TAR and confirmed three days between 7/3/24 and 7/9/24 were documented with two or three 9's indicating the medication was not available. Licensed Practical Nurse (LPN) J documented wound care per physician orders, with inclusion of Santyl nickel thick on during the time period when Santyl was not available in the medication cart. When the DON was asked how Santyl was placed on R51's wound by LPN J, the DON said she understood the question (How could Santyl be placed on the wound when none was available?), but she would have to talk to her nursing staff to figure out what happened. The DON acknowledged the physician order specified Santyl applied to R51's wounds, and none was available for apparently seven days, including that day (7/9/24). When asked if there was any documentation of contact with a physician for a change in the physician order based on the unavailability of the Santyl, the DON stated, I don't see any documentation that anyone was contacted for a change in orders. When asked if the DON understood the concern with the lack of pressure ulcer/wound physician prescribed treatment for one week, the DON confirmed understanding and the potential for worsening of the wounds, and the failure to follow physician orders. During an interview on 7/09/24 at 1:23 p.m., LPN J confirmed she did not have Santyl for R51's wound treatments on the days she worked for the past 7 days. LPN J said she thought the Wound Clinic ordered the Santyl from Chicago. LPN J confirmed that she did not ask anyone about the unavailability of Santyl when she identified it was not available in the medication cart, and confirmed there was no documentation in the EMR showing that anyone had attempted contact with the physician to inquire about a change in orders. When asked about going seven days without the prescribed wound treatment medication, LPN J stated, Yeah, it has been quite a while. Review of the Medication Cross Match policy, implemented 6/21/23, revealed the following: Policy: This facility will perform a medication cross match every week to ensure each resident has a sufficient supply of medications to meet their needs. Policy Explanation and Compliance Guidelines: 1. The facility will utilize a systematic approach to provide routine medications in order to meet the needs of each resident. 2. The nurse assigned to the medication cart on Thursday night will perform a medication cross match. 3. The nurse performing the medication cross match will review and compare the MAR with the medications available in the cart and medication room. 4. Medications found to be at (6) doses or less will be reordered following the facility's medication reorder system. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Reordering policy, implemented 6/21/23, revealed the following, in part: Policy: It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident . 1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting. 4. The nurse that is assigned to each medication cart will perform a medication cross match every Thursday night .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 This deficient practice has two parts: A and B. Part A: Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for one Resident (R24) of five residents reviewed for medication regimen reviews. This deficient practice resulted in the potential for the administration of unnecessary medication or a medication dosage in excess of what was required to treat the resident symptoms. Findings include: Resident R24 Review of R24's Admission Record revealed R24 was admitted to the facility on [DATE] with diagnoses that included the following, in part: Alzheimer's disease, diabetes, hallucinations, psychotic disorder with delusions, depression and generalized anxiety disorder. Review of R24's Physician Order Summary, retrieved 7/11/2024, revealed R24 was prescribed the following psychotropic medications: quetiapine fumarate 25 mg related to psychotic disorder with delusions, and sertraline HCL 75 mg related to depression, Review of R24's [Company Name] Psychological Assessment & Plan, dated 2/8/24, revealed the following, in part: .Alzheimer's disease with late onset. Plan: Due for GDR Seroquel. No new behaviors noted, moods continue to be stable, does well with non pharm (pharmacological) interventions . Stable with Zoloft . Indication for Visit: Follow-Up per the request of patient, family, PCP (primary care provider) or facility staff, GDR, evaluate efficacy of medications and any prior changes. Review of R24's Progress Notes between 1/2024 and 7/2024 found no evidence of acceptance and/or declination of the GDR recommendation for R24's Seroquel. During an interview on 7/9/24 at 3:20 p.m., when asked about a GDR for R24's Seroquel, Social Services Designee (Staff) N, stated, 1/25/24 was the last time they looked at her for a GDR. It should be in [Physician K's] notes. We need to keep track (of the scheduled GDRs). We just did give this (GDR information to the Doctors in June. In January the note would have been contraindicated maybe . I don't know when he last saw her. Staff N and Unit Manager/RN A were asked for any documentation that provided evidence that a Seroquel GDR was attempted or declined by Physician K in the last year. During an interview on 7/9/24 at 4:00 p.m., Staff N and RN A, after review of R24's electronic medical record (EMR), confirmed no GDR was completed by the facility in the last year. No GDR documentation for R24 was available or provided for review. No documented clinical rationale for a lack of an attempted dose reduction for R24's Seroquel was provided by the facility. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Gradual dose Reduction of Psychotropic Drugs, last reviewed 6/17/24, revealed the following, in part: Policy: Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs . 1. Reducing the need for and maximizing the effectiveness of medications shall be considered for all residents who use psychotropic drugs. Therefore, dose reductions and behavioral interventions are part of medication management. This policy pertains to gradual dose reductions. 2. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. 3. After the first year, a GDR will be attempted annually, unless clinically contraindicated . 5. For any individual who is receiving a psychotropic medication to treat expressions or indications of distress related to dementia, the GDR may be considered clinically contraindicated for reasons that include, but that are not limited to: a. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and b. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior . 49310 Part B: Based on interview and record review, the facility failed to ensure accurate antipsychotic medication dosage for one Resident (R26) of five residents reviewed for unnecessary medications. This deficient practice resulted in R26 potentially receiving the incorrect dose of antipsychotic medication. Findings include: Resident #26 Resident #26 (R26) was observed in her room on 7/9/24 at 2:56 p.m. R26 displayed abnormal involuntary facial movement suggestive of antipsychotic medication use. R26 was admitted to the facility with a primary diagnosis of Alzheimer's Disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R26 had a Brief Interview for Mental Status (BIMS) score of 4, indicating R26 was severely cognitively impaired. The MDS documented R26 received antipsychotic medication on a routine basis. Current active medication orders were reviewed. R26's orders included an order for an antipsychotic medication dosed at 3 milligrams (mg) twice daily. The order was entered by a Licensed Practical Nurse (LPN) on 6/20/24 but was not signed by a physician as of 7/9/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26 received services from the facility's contracted provider for psychiatric services. Visit notes from psychiatric services provider dated 6/12/24 documented the current medications for R26 included [name of antipsychotic medication] 0.5 mg tablet (take 4 tablet(s) by oral route 2 times per day) for a total of 2 mg twice daily. There were no visit notes from psychiatric services in the medical record after 6/12/24. The consultant pharmacist (RPh) conducted monthly Medication Regimen Reviews (MRRs) for R26 on 1/19/24, 2/23/24, 3/30/24, 4/30/24, 5/14/24, and 6/19/24. A review of the MRRs revealed no recommendations from the RPH regarding the antipsychotic medication. The last physician visit note in the medical record of R26 was dated 4/25/24. The note documented in part: . Decrease her [name of antipsychotic medication] to 1.5 b.i.d. (1.5 mg twice daily) . [name of antipsychotic medication] 2 b.i.d. (2 mg twice daily) for dementia or the psychosis . On 7/9/24 at 3:16 p.m., Staff N and Registered Nurse A (RN A) were interviewed. Staff N confirmed she was the social services designee, and RN A confirmed she was a nurse manager. Staff N confirmed the last psychiatric service consultation for R26 was 6/12/24. RN A confirmed the last MRR for R26 by the RPh was 6/19/24. Staff N and RN A were asked regarding the dosage discrepancy of the antipsychotic medication between the physician documentation and psychiatric service documentation, and the current order in the medical record. Staff N said the information would be in physician visit documentation. Staff N and RN A reviewed the record of R26 and confirmed the physician did not have progress notes or visit documentation in the medical record since 4/25/24. Staff N said the physician had visited in June (2024) but could not explain why there was no documentation from the physician in June in R26's medical record. Staff N said she would call to obtain the visit documentation notes from the physician for June. On 7/9/24 at 4:06 p.m., Staff N produced a nurse's progress note dated 6/6/24 at 11:01 a.m. that read in part, Dr. [name of physician] was in the facility today . reviewed resident's medications and new order to increase her [name of antipsychotic medication] from 1.5 mg BID (twice daily) to 2 mg BID . Staff N reported R26's physician did not have dictated visit documentation notes from a visit on 6/6/24. The Administrator (NHA) and Director of Nursing (DON) were interviewed on 7/10/24 at approximately 9:15 a.m. The NHA and DON were asked why the dose of antipsychotic medication R26 was receiving was 3 mg twice daily despite the psychiatric service provider and physician documenting 2 mg twice daily with no pharmacy recommendations regarding the antipsychotic medication dose. The NHA and DON were unable to explain the discrepancy. The DON said she would review the information. On 7/10/24 at 12:26 p.m., the DON reported she could not locate information regarding the reason R26 was being administered 3 mg of the antipsychotic medication twice daily. The DON was unable to explain the dose of 3 mg. twice daily.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49310 Based on observation, interview, and record review, the facility failed to ensure inhalers and eye drops were labeled with dates when opened according to facility policy for two medication carts of two medication carts reviewed for medication storage and labeling. This deficient practice resulted in the potential for administration of expired medications to nine residents receiving inhalers and five resident receiving eye drops. Findings include: The 100-hall medication cart was audited on 7/9/24 at 1:33 p.m. with Registered Nurse B (RN B). The cart was observed to contain five bottles of opened eye drops for four different residents. The bottles were not labeled with a date when opened. The cart contained three opened inhalers for two different residents. The inhalers were not labeled with a date when opened. One of the inhalers was inside a clear plastic bag that contained a pharmacy label indicating the pharmacy dispensed the inhaler on 5/30/24. RN B said, They're (inhalers) good for six weeks so that one is expired. The Director of Nursing (DON) was interviewed on 7/9/24 at 1:42 p.m. The DON said eye drops and inhalers should be labeled with a date when they are opened because the discard dates of eye drops and inhalers are based on dates when opened and not the expiration dates. The 300-hall medication cart was audited on 7/10/24 at 8:21 a.m. with Licensed Practical Nurse H (LPN H). The cart was observed to contain two opened eye drop bottles for one resident. The bottles did not contain dates when opened. The cart contained four opened inhalers for two different residents. The inhalers did not contain dates when opened. LPN H said the eye drops and inhalers should be labeled with a date when opened. The policy Labeling of Medications and Biologicals dated 2/2/24 read, in part: .All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications .vials must include: a. The date the vial was initially opened .

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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. 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 57 residents. Findings include: On 7/08/24 at approximately 1:15 PM, Dietary Aide (DA) E was observed conducting dish washing activities in the dish room with the mechanical dish washer. DA E was observed wearing gloves and moving from the soiled side of the dish machine, handling soiled dishes, to the clean side of the dish machine, removing clean dishes from the racks as they exited the machine. DA E did not wash her hands between the soiled side activity and the clean side activity. The FDA Food Code 2017 states: 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (E) After handling soiled EQUIPMENT or UTENSILS On 7/08/24 at approximately 1:20 PM, blue cooling collars were observed hanging from food racks in the walk in cooler (WIC). An interview with Kitchen Manager (KM) D was conducted at this time and learned the blue-ice cooling collars were worn around the neck of staff to assist in body cooling. When asked if the collars were cleaned, KM D stated that they wipe them down. It was further learned that the wiping process used a quaternary (quat) solution and did not include immersion for any period of time. The FDA Food Code 2017 states: 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/08/24 at approximately 1:35 PM, wiping cloths were observed being stored in buckets around the kitchen, including one at the three compartment sink. KM D was requested to demonstrate how the solution was tested to ensure that the proper concentration of sanitizer was present. KM D, pulled a 3 inch strip from the QT 40 test strip dispenser, dipped the strip in for 1 second, then looked at it and began to discard it. When asked what concentration she understood the quat to be from the test conducted, KM D stated about 20. KM D was then requested to read the directions on the dispenser to which she acknowledged that the strip was to be dipped and held in the solution for 10 seconds and the temperature range was to be 65 F to 75 F. The temperature had not been measured prior to the reading and when measured was found to be 101 F. Furthermore, a review of the container of Quat revealed that a minimum of 200 parts per million (PPM) was necessary for the proper sanitizing of food contact surfaces. The FDA Food Code 2017 states: 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (11) Explaining correct procedures for cleaning and SANITIZING UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT; On 7/08/24 at approximately 2:10 PM, the walk in freezer was observed to have a large amount of ice build up on the inside of the door. The ice was indicative of the door seals being damaged or improperly sized which was allowing outside air into the unit, condensing the humidity on the door and contributing to the ice accumulation. During this same observation period, the wall mounted fan directed at the clean end of the dish machine, was observed with dust accumulation on the exterior blade guard. The FDA Food Code 2017 states: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. and 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/9/24 at approximately 8:15 AM, observations were made in the dining room where food was being served from a steam table. The only hand sink available to staff in the dining room was located behind the steam table. Clean plates were stored next to the hand sink and were subjected to splash from the sink when staff came in and washed their hands. Additionally, after staff washed their hands, they had to move their hands to the left, across and over the clean plates, to gain access to the paper hand towels. 49310 During the breakfast meal on 7/9/24 at 7:57 a.m., Staff U was observed removing a baseball-style cap from their head and scratching their scalp before placing the cap back on their head. Staff U began scratching their facial hair before touching the condiments, tableware, and food on a tray next to the serving station. Staff U did not perform hand hygiene after touching their scalp and facial hair and beginning to touch items used or consumed by residents. On 7/9/24 at 8:15 a.m., Staff U began assisting with preparing resident meal trays without performing hand hygiene. At 8:28 a.m., Staff U was observed to be touching the front of their shirt, running their hand from their chest down to their abdomen. Staff U did not perform hand hygiene after touching their shirt and commencing with meal tray set-up. On 7/9/24 at 8:42 a.m., KM D confirmed Staff U was an employee of the Dietary department. KM D said Staff U was a dietary aide. On 7/10/24 at 12:26 p.m., The dining room observation was conveyed to the Administrator (NHA) and Director of Nursing (DON). The NHA and DON were told Staff U did not perform hand hygiene at any time during the breakfast meal observation on 7/9/24. The DON confirmed Staff U was expected to perform hand hygiene after touching his scalp, face, and shirt and before touching resident food items and handling utensils. The policy Hand Hygiene dated 6/15/23 read in part: .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 35103 Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement committee met at least once per quarter with the required committee members resulting in the potential for quality-of-care concerns for all 57 residents in the facility. Findings include: On 7/11/2024 at 7:11 a.m., a review of the available attendance documentation for the QAPI meetings with the Nursing Home Administrator (NHA) revealed the following: Meeting held on 4/30/2024: The Medical Director or designee did not attend. Meeting held on 1/10/2024: No attendance record found. Meeting held on 7/13/24: The Medical Director or designee did not attend. Meeting held on 8/10/23: The Medical Director or designee did not attend. November 2023: No meeting held. No attendance record found. December 2023: No meeting held. No attendance record found. Meeting held on 1/19/24: The Medical Director or designee, and Director of Nursing (DON) did not attend. Meeting held on 2/2/24: The Medical Director or designee did not attend. Meeting held 3/21/24: The Medical Director or designee did not attend. Meeting held 4/11/24: The Medical Director or designee did not attend. Meeting held 5/9/24: The Medical Director or designee and the DON did not attend. (continued on next page)

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	235144	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Village	832 Sicotte St L' Anse, MI 49946

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During this same interview, on 7/11/24 at 7:11 a.m., the NHA said she would look for any notes from QAPI meetings that may have been held in November and December of 2023. The NHA said the potential existed that no sign-in sheets were distributed for signing by all attending individuals. When asked about the lack of Medical Director participation in the QAPI meetings and process, the NHA said Physician K only received payment for dictation he provided for resident care. The DON stated, He (Physician K) didn't want payment for anything for (serving as the) Medical Director. The NHA acknowledged that the facility did not have the required QAPI committee members present during each quarter to meet the regulation pertaining to QAPI committee attendance. A copy of the QAPI Change Process policy, implemented 6/19/24, was provided by the facility in a binder of survey documentation, and also electronically submitted when a QAPI plan policy was requested. During this interview the facility QAPI plan policy was again requested. The QAPI plan policy which detailed the committee member attendance required per CMS (Centers for Medicaid and Medicare Services) regulation and missing attendance records and confirmation of meetings were not provided by survey exit on 7/11/24 at 11:15 a.m. Review of the QAPI CMS regulations revealed the following, in part: .A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (l) The director of nursing services; (m) The Medical Director or his/her designee. (n) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist . The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide and implement an infection prevention and control program. 13791 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive Water Management Plan (WMP) for the control of Legionella in the potable water supply system. This deficient practice has the potential to lead to the growth and proliferation of Legionella in the water supply system and respiratory infections from the Legionella group bacteria affecting all 57 residents. Findings include; On 7/09/24 between 8:45 AM and 10:00 AM observations were made with Maintenance Supervisor (MS) G of the facility's potable water system. A humidifier was identified in the boiler room and explained by MS G that the device provided humidified air into the resident area by aerosolizing potable water via a steam and injected into ventilation air ducts. MS G was asked if this device had been assessed related to the facility's WMP for Legionella control, to which he replied No. When asked what task(s) was/were performed in the control of Legionella, MS G stated the facility collected one sample from the water supply system per year, submitted it to a local laboratory for testing of Legionella. On 7/10/24 a review of the document titled Waterborne Hazards/Legionella Water Management Program, Number ADM-06 ; Revised Date 6-15-23 was conducted. The following was pertinent to the review of the WMP for Legionella control: Section II: Purpose: 3. To implement a water management program that includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens. 4. To specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Section III. PROCEDURE: 2. Director of Environmental service will: b. Identify and control hazardous conditions that increase the chance of Legionella growth and spread. c. Assess how much risk the hazardous conditions in those water systems pose. d. List the building's water systems for which Legionella control measures are needed. e. Apply control measures to reduce the hazardous conditions, whenever possible, to prevent Legionella growth and spread. f. Monitor the program to ensure it is running as designed and is effective. (continued on next page)

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	g. Report findings monthly to the QA Committee. 3. Water Management team a. They will review the elements of the program at least once per year and meet during QAPI meetings at least quarterly 6. Environmental Services will: a. Monitor for internal factors that lead to Legionella, such as inadequate disinfectants, water stagnation, biofilm scale and sediment, fluctuations in water temperature and water pressure changes. c. Check water temperature in the hot water tanks weekly. If the hot water is not at 140 F adjust tempering valve to ensure temperature is at 140 F. Document actions taken. An interview with Maintenance supervisor (MS) G on 7/09/24 at approximately 2:30 pm related to the water management program. MS G stated that no documentation was maintained to disinfectant levels in the water supply, temperature control limits set in the plan or other risks including a humidifier used to increase facility wide humidity level. No policy or procedure was available for review related to the assessment, use or maintenance of the humidifier to reduce the potential for air borne pathogens. On 7/10/24 at approximately 9:45 AM an interview was conducted with MS G concerning the WMP. When asked what was discussed during the quarterly QAPI or monthly QA meetings, MS G stated Well, not Legionella.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49735 Based on interview and record review, the facility failed to ensure nurse aide training of no less than 12 hours per year, for three Certified Nursing Assistants (CNA) P, S, and T of five CNA's reviewed for nurse aide training hours. This deficient practice resulted in the potential for unmet resident care needs for all 57 residents in the facility. Findings include: During an interview on 7/10/24 at 11:19 a.m., Human Resource Staff O revealed the 12 hours of annual CNA training is based on the CNA's hire date. On 7/10/24 at approximately 1:30 p.m., a review of CNA P training log revealed P was hired on 2/25/22 and had only 9.5 hours of in-service training. A review of CNA S training log revealed S was hired 4/13/21 and had only 5 hours of in-service training. A review of CNA T training log revealed T was hired on 5/27/23 and had only 10.25 hours of in-service training. Review of facility policy titled Nurse Aide Training Program implementation date . 4/11/24 read in part, each nurses aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date . Review of the Facility Assessment (FA) last updated . 8/8/23 read in part, required in-service training for nurse aides. In service training must: be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. During an interview on 7/11/24 at 8:24 a.m., the Director of Nursing (DON) and Nursing Home Administrator (NHA) acknowledged staff had not completed the 12-hours of training a year for CNA's

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 49735 Based on interview and record review, the facility failed to ensure training on behavioral health care was provided for two of three staff reviewed for required behavioral health care training. This deficient practice had the potential to result in unmet behavioral health care needs for residents, with the potential to affect all 57 residents in the facility. Findings include: Review of [Vendor] computer training logs on 7/10/24 at approximately 4:00 p.m., revealed the following staff had no behavioral health care training: Certified Nurse Aide (CNA) T was hired on 5/27/23 and CNA S was hired on 4/13/21. Review of policy titled Nurse Aide Training Program implementation date of 4/11/24 read in part, In-service training will be provided by qualified personnel and will be based on the special needs of the residents in the facility. Minimum training will include: . behavioral health . or other behavioral health conditions. Review of Facility Assessment (FA) did not include a requirement for the provision of behavioral health training for staff. During an interview on 7/11/24 at 8:37 a.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) acknowledged the absence of behavioral health training.