STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison St Marshall, MI 49068

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45038 Based on observation, interview and record review the facility failed to ensure safe and clean medical equipment (wheelchair) for one resident (#20) out of 15 residents reviewed. Findings Included: Resident #20 (R20) Review of the medical record revealed R20 was admitted to the facility 11/05/2019 with diagnoses that included Alzheimer's Disease, dysphagia (difficulty swallowing), need for assistance with person care, stage 3 kidney disease, insomnia, repeated falls, osteoarthritis (chronic disease causing breakdown of cartilage in bone joints), major depression, anxiety, epilepsy, anemia (low red blood cells), and hypothyroidism (low thyroid hormone). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/10/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 2 (severe cognitive impairment) out of 15. During observation and attempted interview on 09/18/2024 at 10:58 a.m. R20 was observed sitting up in his wheelchair in the common area of the unit. R20 could not answer during attempted interview. R20's right sided wheelchair arm cushion was observed to be torn and had visible cracks in the vinyl covering. During observation on 09/20/2024 at 11:04 a.m. R20 was observed sitting up in his wheelchair in the common area of the unit. R20's right side wheelchair arm cushion was again observed to be torn and had visible cracks in the vinyl covering. In an interview on 09/20/2024 at 11:05 a.m. Licensed Practical Nurse (LPN) DD explained that if medical equipment needs repair, she would report the issue to the Assistant Director of Nursing (ADON) C. LPN DD denied reporting any concerns with R20's wheelchair and then proceed to go and observe R20's wheelchair. During her observation she identified R20's right side wheelchair arm cushion was torn and had visible cracks in the vinyl covering. LPN DD could not answer how long R20's right side wheelchair arm cushion was in the observed condition. LPN DD explained that a torn and cracked wheelchair arm cushion was an infection control issue because it could not be cleaned adequately. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/20/2024 at 11:26 a.m. Assistant Director of Nursing (ADON) C explained that if medical equipment was in need of repair, she would contact medical device company or the facility maintenance department for repair. ADON C denied that any staff had reported that R20's right side wheelchair arm cushion was in need of repair.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 27446 Based on interview and record review the facility failed to ensure resident emergency transfer notifications were sent to the State Long-Term Care Ombudsman over the last for 41 residents, resulting in the potential for residents being inappropriately transferred or discharged . Findings Included: In an interview on 9/19/2024 at 9:15 AM, the State Long-Term Care Ombudsman R stated she had not received any copies of notifications of resident emergency transfers out of the facility for the last year, and stated she had inquired about them several times to the facility, but had not received any answer nor copies. On 9/19/2024 at 9:30 AM, the Regional Clinical Director (RCD) Q was requested to provide a list of all residents who were emergency transfers out of the facility over the last year, and also provide evidence that the Long-Term Care Ombudsman was provided with a copy of notifications of each resident's emergency transfer notice over the last year. On 9/19/2024 at 4:34 PM, (RCD) Q provided at list of residents over the last year who were emergency transfers out of the facility. (RCD) Q stated that she was not able to locate or provide any proof that copies of the notifications of the last years resident emergency transfers were sent to the Long-term Care Ombudsman. On 9/20/2024 at 11:42 AM, (RCD) Q once again stated that the list of resident who were emergency transfers over the last year was all she could locate, and stated she was not able to provide any documentation or anything else to prove that the resident transfer notification were sent to the Long-Term Care Ombudsman over the last year. Review of the list of residents over the last year revealed that from 9/17/2023 to 8/21/2024, 41 residents had been emergently transferred out of the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45038 Based on observation, interview, and record review the facility failed to complete accurate Minimum Date Set (MDS) assessments for 1 Resident (#33) (use of restraints) of 15 Residents reviewed for accurate MDS Assessments. Findings Included: Resident #33 (R33) Review of the medical record revealed R33 was admitted to the facility 01/17/2019 with diagnoses that included cerebral infarction (stroke), hemiparesis (difficulty moving one side of the body) of the left side, hemiplegia (paralysis one side of the body) of the left side, aphasia (difficulty speaking), dysphagia (difficulty swallowing), weakness, expressive language disorder, type 2 diabetes, contracture of the left knee, contracture of the left elbow, contracture, of the left hand, contracture of the left wrist, contracture of the left hand, hypertension, major depression, muscle spasm and chronic pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. During observation and interview on 09/18/2024 at 08:57 a.m. R33 was observed lying in bed. A side rail was observed on each side of R33's bed. R33 explained that he used the side rails for position himself in bed and used them to assist with setting up prior to getting out of the bed. Review of R33's medical record demonstrated a Minimum Data Set, with an Assessment Reference Date (ARD) of 07/07/2024, section P- Restraints and Alarms was coded used in bed - 2 Bed rail. Review of R33's physician orders demonstrated an order written, 09/19/2024 which stated, side rails/half bars and trapeze on bed to promote independence with bed mobility and transfers. Review of R33's plan of care revealed a problem statement, written 01/18/2019, which stated, Resident requires the use of right enable bar and trapeze r/t(related to) need for assistance with bed mobility and positioning. In an interview on 09/19/2024 at 08:50 a.m. Assistant Director of Nursing (ADON) C explained that side rails were used at the facility but where not always defined as a restraint. ADON C explained if side rails where used for assistance in positioning and they were not restricting the movement of the resident then the side rail would be considered an assistive device and not a restraint. ADON C reviewed R20's plan of care and confirmed that he did not have side rails that were considered restraints. ADON C was asked if the facility completed measurements of side rails that were being used as assistive devices to prevent potential entrapment and ADON C explained that the facility did not measure those devices to prevent potential entrapment. ADON C explained that no resident in the facility was currently using any restraints. ADON C could not explain why R33's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/2024, had been coded that he had two side rails that were considered restraints. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/19/2024 at 08:50 a.m. Minimum Data Set (MDS) Coordinator BB explained that she was responsible for completing the Resident's MDS. MDS Coordinator BB explained that if side rails restricted movement of a resident then they are coded as a restraint and if side rails did not restrict a residents movement then they are coded as an assistive device for mobility. MDS Coordinator BB explained that Assistance Director (ADON) C had informed her that R33 MDS, with and Assessment Reference Date (ARD) of 07/07/2024, section P- Restraints and Alarms had been coded as 2 restraints. MDS Coordinator BB explained that she had coded R33's MDS, with the above listed ARD, and that it was a mistake and should not have been coded as R33 having two restraints. MDS Coordinator BB explained that she would need to correct R33's MDS and resubmit that MDS.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45038 Based on observation, interview, and record review the facility failed to complete and provide a baseline care plan within 48 hours of admission for one Resident (#22) of 1 reviewed for baseline care plan development. Findings Included: Resident #22 (R22) Review of the medical record revealed R22 was admitted to the facility 09/09/2024 with diagnoses that included iron deficiency anemia (low red blood cells), end stage renal disease, depression, weakness, need for assistance with personal care, abnormalities with gait and mobility, heart failure, peripheral vascular disease (PVD), type 2 diabetes, dependence on renal dialysis, severe protein-calorie malnutrition, and atrial fibrillation. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/13/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) of 15. During observation and interview on 09/18/2024 at 09:37 a.m. R22 was observed sitting in her wheelchair at the side of her bed. R22 explained that she did not have any knowledge or know any details regarding her plan of care. R22 denied that she had ever received a copy of her baseline care plan within 48 hours of being admitted to the facility. Review of R22's medical record did not demonstrate that a baseline care plan had been provided to R22. In an interview on 09/19/2024 at 02:54 p.m. Assistant Director of Nursing (ADON) C explained that baseline care plans are provided to the residents within 48 hours of being admitted . ADON C explained that the base line care plan is completed on paper and then is upload into the document section of the resident's chart. ADON C reviewed R22's medical record and could not demonstrate that a base line care plan had been completed or uploaded into R22's medical record. In an interview on 09/10/2024 at 03:27 p.m. Regional Clinical Director (RCD) Q explained that R22's baseline care plan had been completed and was found but was not filed into the resident's medical record until a few minutes ago. RCD Q explained that it was in the possession of Unit Manager D but could not explain why it had not been uploaded to R22's medical record until now. RCD Q explained that the second page of the base line care plan was not completed. RCD Q explained that page two of the care plan would have demonstrated that R22 had reviewed and agreed with her plan of care. RCD Q could not explain why this had not been completed. Review of R22's baseline care plan that was recently placed in the medical record did not demonstrate a date of completion for the document. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy entitled Resident Baseline Care Plan Development , dated 01/17/2028 revealed Intent-To ensure each resident receives necessary care and services upon admission. Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to prevent the development of pressure injuries, including a medical device-related pressure injury, for one resident (Resident #26) out of 4 reviewed for pressure injuries. This deficient practice resulted in resident experiencing harm due to facility-acquired pressure injuries. Findings include: Resident 26 (R26) A review of the medical record indicated that R26 was admitted to the facility on [DATE] with diagnoses including sepsis, osteomyelitis, a sacral pressure ulcer, muscle weakness, and type 2 diabetes. The Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/16/24, reflected that R26 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS), indicating cognitive impairment. On 9/18/24 at 9:18 AM, R26 was observed lying in bed on a pressure-reducing air mattress, dressed in a gown. R26 was positioned flat on the mattress, without pillows to offload pressure or elevate (float) his heels. R26 was conversant, understood questions clearly, and responded appropriately. He reported being admitted with one pressure ulcer on his sacrum and had developed additional ulcers after admission. He stated that a wound vac (negative pressure wound therapy) was applied to the sacral ulcer, and described experiencing severe pain from the pressure ulcers, which prevented him from moving in bed. When asked if staff assisted with repositioning or used pillows to float his heels, R26 said staff did not offer assistance and that he would comply with interventions with assistance and if his pain was properly managed. A single pillow, used to elevate his head, was observed in the room. On 9/18/34 at 11:45 AM, R26 was again observed lying in bed in the same position without pillows to offload pressure or float his heels. A review of his electronic medical record revealed no documented refusals for turning, repositioning, or floating his heels. In an interview at 2:14 PM, Certified Nursing Assistant (CNA) V stated that R26 did not have pillows, wedges, or boots to float his heels. A review of R26's Care Plan for Pressure Ulcer Care, initiated on 8/12/24, indicated that R26 had a Stage 4 pressure ulcer (penetrating all three layers of skin) on his sacrum at the time of admission. The same care plan was revised on 9/17/24 to include a facility-acquired Stage 4 pressure ulcer on his left heel and a facility-acquired Stage 3 pressure ulcer (full-thickness skin loss with damage to subcutaneous tissue) on his left lower buttock. The care plan included interventions such as weekly skin assessments, elevating heels when in bed as the resident allowed, encouraging repositioning every two hours, using a pressure-reducing mattress, treating pain prior to wound care, and using blankets or pillows to cushion bony prominence's. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of R26's Physician Orders revealed an order initiated on 8/19/24 for oxycodone 10 milligrams for severe pain, especially before dressing changes. Another order, initiated on 9/17/24, instructed staff to offer to elevate R26's heels while in bed and to document any refusals. R26's Weekly Skin Assessment documentation showed that the last skin assessment was completed on 8/17/24, with the next one not performed until 9/2/24, meaning more than two weeks had passed without a documented skin assessment. A 9/13/24 skin assessment identified a Stage 3 pressure ulcer on the left heel and another on the left ischium (lower buttock). A Wound Assessment on the same date recorded that the left heel pressure ulcer, first noted on 9/11/24, measured 2.3 cm in length, 3.4 cm in width, and 0.1 cm in depth. Another Wound Assessment on 9/17/24 revealed a left buttock pressure ulcer, first noted on 9/17/24, measuring 2.3 cm in length, 1.2 cm in width, and 0.1 cm in depth. On 9/19/24, a Nurse Practitioner evaluated R26's wounds. The left ischium pressure ulcer was documented as Stage 3, measuring 1.5 cm by 1.0 cm, with moderate serous drainage (clear, watery fluid) and a wound bed consisting of 50% granulation tissue (red tissue) and 50% slough (necrotic tissue). The left heel ulcer was documented as unstageable, measuring 1.2 cm by 2.0 cm with moderate serous drainage, 20% granulation tissue, and 80% slough tissue. On 9/19/24 at 10:56 AM, R26 presented in the same position. R26's pressure-reducing air mattress was observed unplugged. On 9/19/24 at 12:22 PM, R26 presented in the same position. R26's pressure-reducing air mattress remained unplugged. In an interview on 9/19/24 at 12:24 PM, Certified Nursing Assistant (CNA) F PM indicated that she was familiar with R26 and his care needs. CNA F reported that R26 often refused repositioning due to pain and fear of falling, but staff had noticed the lack of repositioning and recently talked about obtaining pillows from laundry to assist. On 9/19/24 at 3:02 PM, R26's pressure-reducing air mattress remained unplugged. R26's heels were floated with the use of a pillow. On 9/20/24 at 12:53 PM, RN D during changing the wound dressing on R26's left buttock wound, another wound was identified by surveyor and RN D. The new would presented as a line and contained areas of slough, The newly identified wound appeared to have occurred from the tubing on the wound vac, which was positioned directly underneath R26 and pressed into the skin underneath the newly identified wound. When asked to describe the newly identified wound, RN D stated that the wound presents as a stage one, possibly a stage two in some spots with areas of slough. When asked how this wound occurred, RN D verified that it appears to have occurred from the wound vac tubing and RN D would classify it as a medical device related pressure injury. During the wound treatment observation, R26 cried out several times during both dressing changes. Review of the medical record revealed that no as needed pain medication was administered prior to the dressing changes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/20/24 at 1:33 PM R26 was heard stating ow from outside of his room. Upon entering R26's room, R26 stated that he was sore after the wound dressing change and that he felt pain about an hour after each wound care dressing change. R26 stated that his current pain level was a 9, and the pain worsens with movement which keeps him from wanting to turn and reposition. R26 reported that he knows that he needs the wound dressing changes for the wounds to successfully heal, however he dreads the wound dressing changes due to the amount of pain that occurs during and after. When asked of the as needed pain medication helps with the pain, R26 stated that he can ask for Tylenol for pain but was completely unaware of any other pain medication order. R26 stated that staff did not regularly ask him about his pain level or offer any as needed pain medication before or after wound care. In an interview on 9/20/24 at 2:11 PM, RN D verified that R26 did not receive any as needed pain medication prior to the wound dressing changes. After reviewing the as needed pain medication Physician order, RN D stated that it would have been appropriate to offer pain medication prior to the dressing change. When asked about R26's reluctance to turn and reposition, RN D stated that in addition to pain, R26 was afraid of falling, therefore, will clutch to the side of the bed. When asked if any anxiety relieving methods were discussed with the Physician or care team, RN D stated that it may have been but could not find any evidence of any intervention or conversation. When asked about the pressure relieving mattress being unplugged, RN D confirmed that it was brought to his attention and that the mattress should be plugged in, as well as a Physician order to verify that the mattress is functioning.

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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. 27446 Based on observation, interview, and record review the facility failed to ensure hand, elbow, and knee splints were placed on and off as directed for one resident (Resident #31) out of one sample for mobility resulting in the potential for worsening of contractors. Findings Include: Per Resident #31's (R31) diagnoses list R31 had contractures of the right elbow, left elbow, right hand, left hand, right lower leg, left lower leg, right knee, left knee, right ankle, and left ankle. On 9/18/2024, at 10:53 AM, R31 was observed In bed with pillows under her knees lying flat on her back. Both of her arms and hands were observed to be contracted. Knee, hand and other splints were observed on a chair in the room. Inside R31's closet door was a posted note attached to the door that instructed to put both knee braces on R31 daily up to or less than 4 hours each time. No braces or splints were observed to be on R31 at the time. On 9/19/2024 at 11:35 AM R31 was observed in her bed, on her back, with pillows under her knees, and the braces/splints remained in the chair. On 9/19/2024 at 2:30 PM, R31 was observed to remain on her back in bed, and the splints/braces remained in the same place on the chair. Review of a care plan dated 4/3/2019 revealed under Problem R31 was at risk for skin breakdown due to reduced mobility and contractures of bilateral upper and lower extremities, and use of splints to both hands, elbows, and knees. The care plan had an Approach dated 3/14/2024, To prevent furthering of elbow contractures and to assist with maintaining good skin integrity in inner elbow: Please put on gray elbow splints daily after providing morning ADL(activities of daily living)/daily care .Tolerates approx 4-6 hrs (hours) with no signs of discomfort. In an observation on 9/20/2024 8:20 AM, R31 was in bed lying on her back, and the braces/splints remained on the chair. During this observation Certified Nurse Aid (CNA) Y stated R31 splints were put on by therapy at noon when therapy saw R31 three times per week. CNAY stated at noon R31's hand splints would be put on, then at 2:00 PM the second shift staff would take them off, and put the arm put the arm splints on. CNA Y said that the days therapy did not treat R31 the CNAs would put the splints on R31. However, CNA Z stated therapy would put the splints on R31 everyday, and said the CNAs did not put the braces/ splints on R31. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview CNA Y and Z both stated that the CNA's did not have copies or the ability to print out a resident's care plan, so the CNA's would have to review each of their resident's care plans in the computer to know how to care for their residents. In an interview on 9/20/2024 at 1:42 PM, Physical Therapist Assistant (PTA) W R31 was to have the both knee splints on every day for up to six hours as R31 tolerated, and said the nursing staff puts them on.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to obtain weights per policy in one of two residents reviewed for nutrition (Resident #26), resulting in the likelihood of inaccuracy of the individual's nutritional status. Findings include: Resident 26 (R26) A review of the medical record indicated that R26 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including sepsis, osteomyelitis, a sacral pressure ulcer, muscle weakness, and type 2 diabetes. The Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/16/24, reflected that R26 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS), indicating cognitive impairment. On 9/18/24 at 9:19 AM, R26 was observed in his room, resting in bed. R26 was conversant, demonstrated a clear understanding of questions, and responded appropriately. R26 reported that he did not care for the taste of the food at the facility, stating that often times he would not consume any breakfast and would refuse a meal at least once a week. When asked if there was alternative food items available, R26 stated I think there's just a peanut butter and jelly sandwich. R26 stated that no one had ever discussed his food likes and dislikes with him. Review of R26's menu ticket revealed no information regarding R26's food likes, dislikes, or preferences. Review of the Physician Order revealed a order initiated on 6/21/24 which stated Weight weekly x(for) 4 weeks following admission. Review of the Physician order revealed and active order initiated on 7/22/24 which stated Monthly Weight Once A Day on 1st Mon (Monday) of the Month. Review of the weigh task revealed the following weights documented in R26's medical record: 6/22/2024 Admission weight: 240 lbs (pounds) 8/12/2024 Readmission weight: 259 lbs 9/09/2024 Weight: 210.3 lbs Review of the medical record revealed no refusals for the other ordered weights. Review of a Registered Dietician note dated 9/14/2024 at 11:12 AM stated Current wt [weight] of 210.3lbs . reflects a wt loss of 48.7lbs (18%) x 28 days . [R26] declines treatments and meals at times. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/20/24 at 2:25 PM, Registered Nurse (RN) D verified that the weekly weights were not documented and no weight refusals were documented. In an interview on 9/20/24 at 3:14 PM, Registered Dietician (RD) P stated that the policy for obtaining weights was weekly for 4 weeks and after that, monthly weights. RD P reported resident that refuse weights should be documented on. Regarding R26's weight loss, RD P reported that she has requested a reweigh on him on 9/16/24, however, it had not been obtained yet. RD P requested the reweight to check for weight accuracy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to ensure proper storage, cleaning and labeling of oxygen/respiratory equipment for two Resident(R18 and R37), of two residents reviewed for oxygen and respiratory care, resulting in the likelihood for cross contamination, respiratory illnesses/disease and increased antibiotic usage. Findings include: Resident #18 (R18) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R18 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure), chronic lung disease, diabetes mellitus, renal failure, heart failure, and heart disease. The MDS reflected R18 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for maximum assistance for transfers, dressing, bathing, dressing and required moderate assist with hygiene and oral care. During initial resident screening on 9/18/24 at 9:17 AM, observed room [ROOM NUMBER]-1 with oxygen concentrator running with oxygen tubing undated and nebulizer equipment on bedside table undated and un-bagged(open to air). During an observation and interview on 9/18/24 at 9:35 AM, R18 was laying in bed with eyes closed and continuous positive airway pressure(CPAP) mask laying on the pillow, next to R18. R18 opened eyes and reported was tired. Oxygen concentrator was running with oxygen tubing dated 9/2/24. Review of R18 Physician orders, dated 9/1/23, reflected, Resident is to use CPAP when sleeping. Continued review of the physician orders, dated 10/2/23, reflected, Oxygen per Nasal Cannula at 2 liters continuous for resident comfort or Oxygen saturations below 90%. During an interview and record review on 9/20/24 at 12:35 PM, Infection Control Nurse(ICN) C reported had been in the position for about three months. During the Infection Control review ICN C reported R18 was diagnosed with facility acquired pneumonia July 2024 after review of the Infection Control line listing log. Review of R18 Provider note, dated 7/31/2024 at 11:11 PM, reflected, CHIEF COMPLAINT .Acute SOB[short of breath] over the weekend, PNA[pneumonia] HISTORY OF PRESENT ILLNESSES General: [named R18] is a [AGE] year-old female who is seen today for follow up to acute sob over the weekend. She denies new acute pain at this time. She tells me her breathing has improved and she is coughing less. She continues on Bactrim, NMTs and routine inhalers. She denies fever/chills/bodyaches, G.I./GU disturbances. No other medical concerns are reported . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Risk of Complications and/or Morbidity or Mortality of Patient Management: MODERATE J18.9 - Pneumonia, unspecified organism: Started 7/28 Augmentin 500/125mg PO BID x5 days. DuoNeb's TID, Albuterol inhaler prn q4 hrs. Mucinex 600mg BID Continue [NAME] Continue CPAP with supplemental O2 to maintain Os sat greater than 88% .Chronic diastolic (congestive) heart failure: Additional dose Diuretic given 7/28 Lasix 40mg x 1 . Obstructive sleep apnea (adult) (pediatric): Continue CPAP. Continue oxygen . Review of R18 Provider notes, dated 7/29/24, reflected, CHIEF COMPLAINT Acute SOB over the weekend HISTORY OF PRESENT ILLNESSES General: [named R18] is a [AGE] year-old female who is seen today for acute sob over the weekend. She denies new acute pain at this time, no chest pain with inspiration. CXR was done and demonstrated pulmonary vascular congestion as well as BLLL infiltrates. She was started on Bactrim[chronic urinary tract infection], by on call provider. She tells me she has been unable to transition from her CPAP to NS since symptoms started. She feels comfortable in breathing with the CPAP on. She has had infrequent cough and upper left chest congestion. She continues with use of inhalers with mild relief . Imaging: CXR 7/28/2024: Demonstrated pulmonary vascular congestion as well as BLLL infiltrates . ASSESSMENTS AND PLANS Risk of Complications and/or Morbidity or Mortality of Patient Management: MODERATE J18.9 - Pneumonia, unspecified organism: Started 7/28 Augmentin 500/125mg PO BID x5 days. DuoNeb's TID, Albuterol inhaler prn q4 hrs Mucinex 600mg BID Continue [NAME] Continue CPAP with supplemental O2 to maintain Os sat greater than 88% I50.32 - Chronic .diastolic (congestive) heart failure: Additional dose Diuretic given 7/28 Lasix 40mg x 1 .Obstructive sleep apnea (adult) (pediatric): Continue CPAP. Continue oxygen . Resident #37(R37) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R37 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure), chronic lung disease, diabetes mellitus, renal failure, and heart disease. The MDS reflected R18 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. During an observation on 9/18/24 at 9:49 a.m., R37 was observed in bed and able to answer questions without difficulty. R37's oxygen concentrator was running with nasal cannula laying directly on bed linens and nebulizer equipment was laying directly on cushion of wheelchair located near the foot of the bed. During an interview on 9/20/24 at 3:56 PM, Assistant Director of Nursing/Infection Control Nurse (ADON/ICN) C reported would expect staff to change oxygen tubing every 7 days and date including nebulizer tubing/equipment should be rinsed after use and stored inside bag.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review the facility failed to ensure pain medications were given as ordered for one (resident #26) of two reviewed for pain, resulting in resident experiencing harm with uncontrolled pain. Findings include: Resident 26 (R26) A review of the medical record indicated that R26 was admitted to the facility on [DATE] with diagnoses including sepsis, osteomyelitis, a Stage 4 sacral pressure ulcer (full thickness skin loss that extends into muscle, bone or supporting structures) , muscle weakness, and type 2 diabetes. The Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/16/24, reflected that R26 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS), indicating cognitive impairment. On 9/18/24 at 9:18 AM, R26 was observed lying in bed on a pressure-reducing air mattress, dressed in a gown. R26 was positioned flat on the mattress, without pillows to offload pressure or elevate (float) his heels. R26 was conversant, understood questions clearly, and responded appropriately. He reported being admitted with one pressure ulcer on his sacrum and had developed additional ulcers after admission. He stated that a wound vac (negative pressure wound therapy) was applied to the sacral ulcer, and described experiencing severe pain from the pressure ulcers, which prevented him from wanting to be moved in bed. R26 stated that the pain is excruciating during wound care, rating his pain at a 9 to a ten during and after wound care. A review of R26's Care Plan for Pressure Ulcer Care, initiated on 8/12/24, indicated that R26 had a Stage 4 pressure ulcer (penetrating all three layers of skin) on his sacrum at the time of admission. The same care plan was revised on 9/17/24 to include a facility-acquired Stage 4 ulcer on his left heel and a facility-acquired Stage 3 ulcer (full-thickness skin loss with damage to subcutaneous tissue) on his left lower buttock. The care plan included an intervention to treating pain prior to wound care. A review of the same Care Plan revealed a focus are for pain, which stated, R26 has the potential for pain related to: osteomyelitis, stage 4 sacral wound, recent left fibula fracture, and left knee pain and swelling. Interventions included to administer pain medication as ordered. A review of R26's Physician Orders revealed an order initiated on 8/15/24 and discontinued on 8/19/24 for Oxycodone (pain relieving medication) 5 milligrams (mg) every four hours as needed. Instructions on the order stated give in addition to schedule [oxycodone] dose before dressing changes. The Oxycodone was not administered 8/15/24-8/19/24. A review of R26's Physician Orders revealed an active order initiated on 8/19/24 for Oxycodone 10 mg as needed every 6 hours for severe pain and before dressing changes. May give long acting [oxycodone] and short acting together. Review of the Physician Order's revealed daily wound care for R26's sacral wound. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The as needed and before dressing changes Oxycodone 10 mg was only administered on the following dates/times: 8/22/24 one dose at 6:27 pm 8/23/24 one dose at 5:26 pm 8/28/24 one dose at 7:51 am 8/29/24 one dose at 3:31 pm 9/1/24 one dose at 4:55 pm 9/14/24 one dose at 10:02 am 9/15/24 one dose at 7:55 am 9/19/14 one dose at 9:58 am Review of the Physician Order revealed two orders were initiated on 9/17/24 daily wound care for R26's left heel and left buttock wound. Review of a Physician Note dated 8/26/24 reflected R26 was seen by the nurse practitioner for follow up to pain for sacral wound and anxiety R26's pain regimen was adjusted to long acting 12hr Oxycodone . He tells me his pain is better than previously noted. He still has increased pain with wound care and is fearful and reluctant to turn in bed, creating increased anxiety that he will become dizzy to the point where he refuses incontinence care and wound care . Review of a Physician Note dated 9/4/24 reflected R26 was seen for follow up to pain for sacral wound and anxiety .Pain regimen was adjusted to long acting 12hr Oxy [oxycodone]. He tells me his pain is better than previously noted but with increased pain with wound care . On 09/19/24 at 12:12 PM, Registered Nurse (RN) H reported that R26 refuses wound care and turning and repositioning due to pain. On 09/19/24 at 3:15 PM. Licensed Practical Nurse (LPN) AA reported that R26 will often refuse wound care and turning and repositioning due to pain. In an interview on 9/19/24 at 12:24 PM, Certified Nursing Assistant (CNA) F PM indicated that she was familiar with R26 and his care needs. CNA F reported that R26 often refused repositioning due to pain and fear of falling. On 9/20/24 at 12:49 PM, Registered Nurse (RN) D was in R26's room and reported that he was finishing up R26's care and getting R26 ready for the wound care observation. RN D closed R26's door. R26 was heard crying out during care. On 9/20/24 at 12:53 PM, during the wound treatment observation, R26 cried out several times during both left heel and left buttock dressing changes. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed that no as needed pain medication was administered prior to the dressing changes. On 9/20/24 at 1:33 PM R26 was heard stating ow from outside of his room. After entering R26's room, R26 stated that he was sore after the wound dressing change and that he felt pain about an hour after each wound care dressing change. R26 stated that his current pain level was a 9, and the pain worsens with movement which keeps him from wanting to turn and reposition. R26 reported that he knows that he needs the wound dressing changes for the wounds to successfully heal, however he dreads the wound dressing changes due to the amount of pain that occurs during and after. When asked of the as needed pain medication helps with the pain, R26 stated that he can ask for Tylenol for pain but was completely unaware of any other pain medication order. R26 stated that staff did not regularly as him about his pain level or offer any as needed pain medication before or after wound care. Record Review revealed pain assessments were being completed but were not consistent with what R26 was reporting. In an interview on 9/20/24 at 2:11 PM, RN D verified that R26 did not receive any as needed pain medication prior to the wound dressing changes. After reviewing the as needed pain medication Physician order, RN D stated that it would have been appropriate to offer pain medication prior to the dressing change.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review the facility failed to provide ongoing communication and collaboration with the contracted dialysis facility regarding dialysis care for one resident (#29) of one resident reviewed resulting in ineffectively tracking weights and the potential for unmet care needs. Finding Include: Resident #29 (R29) Review of the medical record revealed R29 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included end stage renal disease and a binge eating disorder. Review of the Minimum Data Set revealed R29 received dialysis services. On 9/18/24 at 1:12 PM, R29 was observed in his room. R29 reported no concerns with his dialysis care, however, reported that sometimes the dialysis place doesn't send back the filled-out forms. Review of the Physician's Orders revealed an active order initiated on 08/07/2024 for a weekly weight. Review of the medical record revealed the following weights: 9/20/2024 7:06 AM Weight: 374 lbs (pounds) 8/30/2024 07:30 AM Weight: 405 lbs 8/22/2024 03:50 PM Weight: 408.7 lbs 8/09/2024 03:21 PM Weight: 411 lbs 8/05/2024 01:40 PM Weight: 411 lbs 7/15/2024 01:17 PM Weight: 365.86 lbs No refusals for the weekly ordered weights were documented in the medical record. Review of R29's Dialysis Communication Binder revealed a stack of Dialysis Communication forms which included information such as a pre dialysis assessment completed by the facility and a post dialysis assessment to be completed by the dialysis unit. The post dialysis communication form included a section for documentation of vitals, a pre-dialysis weight, and a post-dialysis weight. Review of the Dialysis Communication forms were incomplete by the dialysis facility for the following dates: 8/15/24 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/17/24 8/22/24 8/27/24 9/12/24 9/14/24 In an interview on 9/20/24 at 1:52 PM, Registered Nurse (RN) D stated that R29 was refusing to be weighted at the facility, so, they came to an agreement to use the dialysis obtained weight. RN D acknowledged that R29 had an order for weekly weights, however, the weights were not documented in his medical record per order. RN D stated that dialysis has not been completing the dialysis communication forms on a regular basis and the expectation would be to have it completed and returned to the facility.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 45038 Based on observation, interview, and record review the facility failed to ensure that bed rails were assessed and measured to prevent possible entrapment for one Resident (#33) of one resident reviewed for Residents using bed rails. Findings Included: Resident #33 (R33) Review of the medical record revealed R33 was admitted to the facility 01/17/2019 with diagnoses that included cerebral infarction (stroke), hemiparesis (difficulty moving one side of the body) of the left side, hemiplegia (paralysis one side of the body) of the left side, aphasia (difficulty speaking), dysphagia (difficulty swallowing), weakness, expressive language disorder, type 2 diabetes, contracture of the left knee, contracture of the left elbow, contracture, of the left hand, contracture of the left wrist, contracture of the left hand, hypertension, major depression, muscle spasm and chronic pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 11 (moderate cognitive impairment) out of 15. During observation and interview on 09/18/2024 at 08:57 a.m. R33 was observed lying in bed. A side rail was observed on each side of R33's bed. R33 explained that he used the side rails for position himself in bed and used them to assist with setting up prior to getting out of the bed. Review of R33's medical record demonstrated a Minimum Data Set, with an Assessment Reference Date (ARD) of 07/07/2024, section P- Restraints and Alarms was coded used in bed - 2 Bed rail. Review of R33's physician orders demonstrated an order written, 09/19/2024 which stated, side rails/half bars and trapeze on bed to promote independence with bed mobility and transfers. Review of R33's plan of care revealed a problem statement, written 01/18/2019, which stated, Resdident requires the use of right enable bar and trapeze r/t(related to) need for assistance with bed mobility and positioning. The medical record also demonstrated a Observation Detail List Repot: Interdisciplinary Enabler/Physical Restraint Assessment, dated 09/13/2024 which demonstrated number 11 -IF enabler or bedside rails are utilized, were the following completed which revealed the following had been completed: assesses resident for risk of entrapment, informed consent, correct instillation, ensuring resident size and weight re appropriate to bed dimensions, and maintenance of rails had been completed. In an interview on 09/19/2024 at 08:50 a.m. Assistant Director of Nursing (ADON) C explained that side rails were used at the facility. ADON C was asked if the facility completed measurements of side rails that were being used as assistive devices to prevent potential entrapment and ADON C explained that the facility did not measure those devices to prevent potential entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy entitled Bed/Side Rail Use, dated 04/2028 and last reviewed 01/2024, revealed in procedure #6 Maintenance staff will install according to manufacturer's recommendations to ensure resident size and weight are appropriate for the beds dimensions. A 5 Day/Side Bed Rail assessment is to be initiated prior to any rail installation. In an interview on 09/29/2024 at 09:16 a.m. Regional Clinical Director (RCD) Q explained that bed rail assessments with measurements are to be completed at the time of bed rail instillation and are also to be completed quarterly. When R33's bed rail assessments were requested RCD Q explained that she would have to locate the documents. In an interview on 09/2024 at 09:38 a.m. Regional Clinical Nurse (RCD) Q explained that no bed rail measurements for R33 could be found. RCD could not explain why R33 had not had bed rail measurements completed on bed rail installation or quarterly.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 27446 Based on observation, interview, and record review the facility failed to ensure a medication error rate less than 5% resulting in an error rate of 16%. Findings Included: During an observation on 9/19/2024 at 7:50 AM, of medication administration, Registered Nurse (RN) T was observed to put five pills into a medication cup that she had put a spoonful of pudding into. One of the pills RN T was observed to put in the medication cup was a Hyoscyamine 0.25 mg tablet (used for stomach issues). RN T was then observed to administered the pudding with all five of the pills into R38's mouth, and observed R38 to swallow the pudding and the pills. Review of R38's medication administration record revealed the order RN T administered for the Hyoscyamine 0.25 mg pill was ordered to be administered sublingual, meaning place under the tongue to dissolve, and not swallow. During an observation of medication administration (MAR) on 9/19/2024 at 8:00 AM, RN U was observed to administer R15's Flomax (used to treat enlarged prostate) 0.4 mg tablet to him while he sat in the dining at at table. RN U was asked if R15 had eaten his breakfast yet that morning. RN U stated no R15 had not. Review of R15's MAR with RN U revealed R15's Flomax 0.25 mg tablet was ordered to be given after breakfast. RN U then stated R15 had some snacks, but not breakfast, as the order stated. After RN U gave R15 the medication cup with an unknown amount of pills in it, she did not observe R15 swallow the pills, but instead walked back to the medication cart at the nurse's station, which was behind R15. R15 was observed to put the medication cup up to his mouth, and take in an unknown amount of the pills, with two pills falling out of the medication onto the floor, unbeknownst to RN U. RN U was approached after approximately two minutes and asked if she knew that two of R15's pills fell on to the floor. RN U stated, He always does that, however did not assure R15 swallowed the pills and not drop them on the floor know R15 does that. RN U then was observed to get R15's Toujeo insulin (long acting insulin) pen (has a needle which is used to inject insulin just under the skin) out of the medication cart, and stated that she would have to poke R15 twice because the pen only had 80 units of insulin in it and she would have to give another 5 units from another pen. RN U was observed to not prime the insulin pen with 2 units of insulin (in order to ensure the needle would not inject air under R15's skin, and ensure the full dose of insulin was administered) prior to administering the 80 units of insulin to R15. RN U was then observed to obtain a new insulin pen and not prime the needle prior to administering R15 the remaining 5 units of insulin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN U was asked why she did not prime the insulin needles, in which RN U stated, I am not from around here. RN U was then asked about her education on the use of insulin pens, in which RN U stated, I am agency (travel nurse). Review of the facility's policy and procedure titled, Guidance for Using Insulin Products revealed on page #1, #7. Prime pen-like devices prior to each and every injection to minimize air bubbles. Dial units as per below guidance and push until a drop of insulin is seen at the top of the needle. Per the guidance for a Toujeo U-300 3 units are used to prime, and for a Toujeo Max U-300 4 units of insulin to prime.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to ensure medications/treatment carts remained secured in 2 of 3 medication/treatment carts reviewed, resulting in the potential unsafe access to medications. On 9/18/24 at 12:10 PM, two treatment carts located in the resident's dining room (North [NAME]) were observed to be unlocked. The cart drawers were opened revealing wound treatment supplies, including several prescribed topical medications. On 9/19/24 at 9:01 AM, the same treatment carts remained unlocked. On 9/19/24 at 10:24 AM, the same treatment carts remained unlocked. On 9/19/24 at 12:21 PM, one of the treatment carts was observed to be unlocked. The cart drawers were opened revealing wound treatment supplies, including several prescribed topical medications. On 9/19/24 at 3:11 PM, Regional Clinical Director Q observed the unlocked treatment cart, proceeded to lock it, and stated that the treatment carts should be locked. 27446 During an observation of medication administration on 9/19/2024 at 8:00 AM, Registered Nurse (RN) U was observed to be at the medication cart putting a resident's pills in a medication cup to administer. Upon completion RN U was observed to walk away from the medication cart that was by the nurses station, and leave the medication cart unlocked, and the computer open with the resident's medical record exposed to anyone who was in view or walked by the computer. RN U was observed to administered the medications to a resident who was sitting at a table in the dining area, the medication cart was in RN U view, however only the back of the cart was in view, and RN 15 was observed to have her back turned towards the back of the medication while she administered the resident their medications.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, and record reviews, the facility failed to provide palatable food products effecting 49 residents, resulting in the increased likelihood for resident decreased food acceptance and nutritional decline. Findings include: On 09/18/24 at 12:06 P.M., Resident #44 was observed seated at the table awaiting her lunch meal, within the Forest Dining Room. Resident #44 was also observed removing the meal tray upper insulation cover and stating: What the hell is this! referring to her lunch meal food products. On 09/18/24 at 12:10 P.M., Lunch meal food trays were observed leaving the food production kitchen, within an insulated transport cart. On 09/18/24 at 12:09 P.M., Lunch meal food trays were observed arriving to [NAME] (North) Dining Room. On 09/18/24 at 12:13 P.M., Food product temperatures were monitored utilizing a ThermoWorks Superfast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #1's lunch meal: Burrito - 138.7 Spanish Rice - 142.7 Corn - 126.2* Beverage (2% Milk) - 49.7* (*) The 2017 FDA Model Food Code section 3-501.16 states: (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: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. On 09/18/24 at 12:18 P.M., An interview was conducted with Resident #1 regarding facility food products. Resident #1 stated: The food is not that good. On 09/18/24 at 12:35 P.M., Lunch meal food products were monitored by this surveyor for taste, texture, and palatability. The Beef Burrito was observed semi-tough and somewhat dry to the palate. The Spanish Rice was also observed starchy and somewhat dry to taste. The Corn was further observed flat and tasteless. The Fruit Punch beverage was additionally observed flavorful and sweet. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/19/24 at 10:30 A.M., An interview was conducted with Dietary Manager K regarding the alternate meal procedure. Dietary Manager K indicated her staff assigns an alternate meal choice the morning of the meal substituting only the main entree. Dietary Manager K also indicated she is currently working on implementing an always available menu option for residents. Dietary Manager K further stated: I plan to start the new menu option on Monday. On 09/19/24 at 11:49 A.M., An interview was conducted with Dietary [NAME] N regarding the facility food tray delivery schedule. Dietary [NAME] N stated: We deliver [NAME] (South), Forest Hall, and then [NAME] (North). On 09/19/24 at 12:11 P.M., Lunch meal food trays were observed leaving the food production kitchen, within an insulated transport cart. On 09/19/24 at 12:12 P.M., Lunch meal food trays were observed arriving to the [NAME] (North) Dining Room. On 09/19/24 at 12:14 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #22's lunch meal: Spaghetti with Meat Balls - 111.1* Tossed Salad - 51.5* Sponge Cake with Whipped Topping - Room Temperature Beverage - Note: No beverage was provided on Resident #22's lunch meal food tray. (*) The 2017 FDA Model Food Code section 3-501.16 stated: (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: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. On 09/19/24 at 12:16 P.M., An interview was conducted with Resident #22 regarding facility food products. Resident #22 stated: I haven't eaten any of the food since I got here. On 09/19/24 at 12:30 P.M., Record review of Resident #22's face sheet dated 08-09-24 revealed Resident #22 was admitted to the facility on [DATE]. 46954 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/18/24 at 9:19 AM, Resident #26 (R26) was observed in his room, resting in bed. R26 was conversant, demonstrated a clear understanding of questions, and responded appropriately. R26 reported that he did not care for the taste of the food at the facility, stating that often times he would not consume any breakfast and would refuse a meal at least once a week. When asked if there was alternative food items available, R26 stated I think there's just a peanut butter and jelly sandwich. R26 stated that no one had ever discussed his food like and dislikes with him. On 9/18/24 at 10:08 AM, Resident #41 (R41) reported that the food at the facility was not good. R41 stated that if you don't like the food being offered, staff will provide her with the supplies to make her own peanut butter and jelly. R41 was unaware of any other alternative food options. O9/18/24 at 10:28 AM, Resident #13 (R13) reported that the food is gross and wished that people from corporate would come try the food themselves. R13 stated if resident do not like the meal being offered, they have to notify staff of an alterative option, however, there was no alternative menu available for residents. R13 stated that the facility has been promising to create an alternative menu for months. On 9/18/24 at 12:09 PM, Residents in the [NAME] North dining room were being served lunch which consisted of a beef burrito, Spanish rice, and corn. 4 residents were seated in the dining room and their plates were observed. The lunch did not appear appetizing and the Spanish rice was placed on all 4 residents places in a form of a scoop. On 9/19/24 at 9:04 AM, the facility dining rooms were observed and confirmed no display of an alternative menu. On 9/19/24 at 12:53 PM, a lunch meal was provided to this surveyor for taste, texture, and palatability. The spaghetti sauce was salty, and the taste was comparable to tomato paste. The meatballs were not appetizing. On 09/19/24 at 10:30 A.M, an interview was conducted with Dietary Manager K regarding the alternate meal procedure. Dietary Manager K indicated her staff assigns an alternate meal choice the morning of the meal substituting only the main entree. Dietary Manager K also indicated she is currently working on implementing an always available menu option for residents. Dietary Manager K further stated: I plan to start the new menu option on Monday.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 During observation and interview, the facility failed to provide alternative food choices for 3 Residents (#13, 26,41) resulting in the potential frustration of residents and a non-pleasurable dining experience. On 9/18/24 at 9:19 AM, Resident #26 (R26) was observed in his room, resting in bed. R26 was conversant, demonstrated a clear understanding of questions, and responded appropriately. R26 reported that he did not care for the taste of the food at the facility, stating that often times he would not consume any breakfast and would refuse a meal at least once a week. When asked if there was alternative food items available, R26 stated I think there's just a peanut butter and jelly sandwich. R26 stated that no one had ever discussed his food like and dislikes with him. On 9/18/24 at 10:08 AM, Resident #41 (R41) reported that the food at the facility was not good. R41 stated that if you don't like the food being offered, staff will provide her with the supplies to make her own peanut butter and jelly. R41 was unaware of any other alternative food options. O9/18/24 at 10:28 AM, Resident #13 (R13) reported that the food is gross and wished that people from corporate would come try the food themselves. R13 stated if resident do not like the meal being offered, they have to notify staff of an alterative option, however, there was no alternative menu available for residents. R13 stated that the facility has been promising to create an alternative menu for months. On 9/18/24 at 12:09 PM, Residents in the [NAME] North dining room were being served lunch which consisted of a beef burrito, Spanish rice, and corn. 4 residents were seated in the dining room and their plates were observed. The lunch did not appear appetizing and the Spanish rice was placed on all 4 residents places in a form of a scoop. On 9/19/24 at 9:04 AM, the facility dining rooms were observed and confirmed no display of an alternative menu. On 9/19/24 at 12:53 PM, a lunch meal was provided to this surveyor for taste, texture, and palatability. The spaghetti sauce was salty, and the taste was comparable to tomato paste. The meatballs were not appetizing. On 09/19/24 at 10:30 A.M., An interview was conducted with Dietary Manager K regarding the alternate meal procedure. Dietary Manager K indicated her staff assigns an alternate meal choice the morning of the meal substituting only the main entree. Dietary Manager K also indicated she is currently working on implementing an always available menu option for residents. Dietary Manager K further stated: I plan to start the new menu option on Monday.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 49 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and cross-connections between the potable (drinking) and non-potable (non-drinking) water supplies. Findings include: On 09/18/24 at 08:58 A.M., An initial tour of the food service was conducted with Dietary [NAME] M. The following items were noted: Packing shrink wrap was observed peeling and partially intact on both interior door surfaces of the Beverage-Air 2-Door Cooler (#1). Packing shrink wrap was observed peeling and partially intact on both exterior door surfaces of the BlueAir 2-Door Cooler (#2). The can opener assembly was observed soiled with accumulated and encrusted food residue. The Sharp microwave oven interior was observed soiled with accumulated and encrusted food residue. The [NAME] stand mixer spindle gear cover and backsplash were observed soiled with accumulated and encrusted food residue. The [NAME] stove/oven/griddle was observed soiled with accumulated and encrusted food residue. The griddle corner edges and side splash plate were also observed heavily soiled with accumulated and encrusted food residue. The oven backsplash was additionally observed soiled with accumulated and encrusted food residue. The oven exterior door surfaces and perimeter ledges were further observed soiled with accumulated and encrusted food residue. The garbage disposal overhead spray arm valve assembly was observed heavily soiled with accumulated and encrusted food residue. The broom waste caddies (2) were observed heavily soiled with accumulated and encrusted dust, dirt, and grime. The Dry Storage Room overhead light assembly plastic lens covers were observed soiled with dust, dirt, and dead insect carcasses. The Mechanical Dish Machine ventilation hood interior and exterior surfaces were observed soiled with accumulated and encrusted corroded moisture stains. The ventilation hood plenum interior was also observed heavily soiled with accumulated and encrusted dust, dirt, and grime. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The three-compartment sink polyvinyl chlorine (PVC) waste lines were observed heavily soiled with (dirt, grease, grime). The three-compartment sink waste lines (2) were also observed direct plumbed without an effective airgap. The 2017 FDA Model Food Code section 5-202.13 states: An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonFOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). The three-compartment sink polyvinyl chloring (PVC) waste line floor receptacle was observed heavily soiled with accumulated and encrusted (dust, dirt, and grime). The 2017 FDA Model Food Code section 6-501.12 states: (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing. On 09/18/24 at 10:05 A.M., An initial tour of the facility dietary Kitchenettes was conducted with Dietary Manager O. The following items were noted: [NAME] (North) Kitchenette: The overhead light assembly plastic lens cover was observed soiled with dead insect carcasses (8). The return-air-exhaust ventilation grill, adjacent to the oven/stove, was also observed with accumulated dust and dirt deposits. The return-air-exhaust ventilation grill, located directly above the washer/dryer, was additionally observed heavily soiled with accumulated and encrusted dust/dirt deposits. Dietary Manager O indicated she would contact maintenance as soon as possible for necessary cleaning and/or repairs. [NAME] (South) Kitchenette: The return-air-exhaust ventilation grill, located directly above the washer/dryer, was observed heavily soiled with accumulated and encrusted dust/dirt deposits. The overhead light assembly plastic lens cover was also observed soiled with dead insect carcasses (5) and dust/dirt deposits. Dietary Manager O indicated she would contact maintenance as soon as possible for necessary cleaning and/or repairs. Forest Hall Kitchenette: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. Packaging shrink wrap was also observed on the interior ventilation hood surfaces and return-air-exhaust grill. One box of white plastic spoons was further observed opened and uncovered. The overhead light assembly plastic lens cover was additionally observed soiled with dead insect carcasses and dust/dirt deposits. Dietary Manager O indicated she would contact maintenance as soon as possible for necessary cleaning and/or repairs. On 09/20/24 at 01:45 P.M., Record review of the Policy/Procedure entitled: Cleaning Hoods and Filters dated (no date) revealed under Policy: Hoods and filters will be thoroughly cleaned on a regular basis. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/20/24 at 02:00 P.M., Record review of the Policy/Procedure entitled: Cleaning Solid Top Ranges dated 4/21 revealed under Policy: Solid top ranges will be cleaned and sanitized on a regular basis. On 09/20/24 at 02:15 P.M., Record review of the Policy/Procedure entitled: Sanitizing Bench Can Opener dated 4/21 revealed under Policy: The bench can opener will be cleaned and sanitized after each use. On 09/20/24 at 02:30 P.M., Record review of the Policy/Procedure entitled: Cleaning Ovens dated 4/21 revealed under Policy: Ovens will be cleaned and sanitized on a regular basis. On 09/20/24 at 02:45 P.M., Record review of the Policy/Procedure entitled: Cleaning Outside of Ranges dated 4/21 revealed under Policy: Ranges will be cleaned and sanitized on a regular basis. Record review of the Policy/Procedure entitled: Cleaning Outside of Ranges dated 4/21 further revealed under Procedure: (1) Scrub front, sides, and back with detergent solution or degreaser, if there is build-up. On 09/20/24 at 03:00 P.M., Record review of the Policy/Procedure entitled: Cleaning Grill dated 4/21 revealed under Policy: The grill will be thoroughly cleaned on a regular basis.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively maintain the outdoor waste receptacle effecting 49 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and pest attraction/harborage. Findings include: On 09/18/24 at 10:05 A.M., An environmental tour of the outdoor waste receptacle pad and container was conducted with Dietary Manager K. The following items were noted: The outdoor waste receptacle was observed missing the rear sliding door. The outdoor waste receptacle was observed with 1 of 2 swinging doors cracked and broken, increasing the likelihood for pest attraction/harborage. Dietary Manager K indicated she would contact the current waste removal company for necessary repairs as soon as possible. On 09/20/24 at 09:00 A.M., Record review of the Policy/Procedure entitled: Sanitizing Garbage Cans and Dumpsters dated 08/23 revealed under Policy: Garbage cans will be thoroughly cleaned and sanitized on a regular basis. Record review of the Policy/Procedure entitled: Sanitizing Garbage Cans and Dumpsters dated 08/23 further revealed under Procedure: (6) Report any leaks, cracks, dents, or rust in the container or lid to the Dietary Manager so that it can be replaced. (8) Dumpsters provided by the local refuge vendor will be maintained by the facility and kept covered at all times. (9) Area around the dumpster will be kept clean, free of debris, foul odors, and free of harboring/feeding of pests.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 45038 Based on observation, interview, and record review the facility failed to coordinate hospice services for one resident (#38) out of one resident reviewed for coordination of hospice services resulting in the potential for care note being provided to resident receiving hospice services and the potential for residents not to be fully informed of hospice services provided. Findings Included: Resident #38 (R38) Review of the medical record revealed R38 was admitted to the facility 10/29/2021 with diagnoses that included pneumonia, frontotemporal neurocognitive disorder, dysphagia (difficulty swallowing), muscle weakness, need for assistance with personal care, dementia, anxiety, insomnia, depression, chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2024, demonstrated a Brief Interview for Mental Status (BIMS) of 11(moderate cognitive impairment) of 15. Section 0-Special Treatments, Procedures, and Programs of the MDS, with the same ARD, demonstrated R38 had been receiving Hospice care while a resident at the facility. During observation and interview on 09/18/2024 at 09:14 a.m. R38 was observed lying in bed. R38 explained that he was received Hospice services. R38 explained that a hospice nurse would come once a week but did not know when she was coming to see him again. R38 could not explain how often or when a hospice aid provided care to him. When asked if he was provided a Hospice Calander explaining what disciplines provided hospice services and when those services were to be provided, R38 explained he was not provided a hospice Calander. No Hospice Calander was observed in R38's room. Review of R38's medical record revealed a physician order dated 07/08/24 (name of agency) Hospice Dx COPD and (number of agency). Review of R38's plan of care did have a problem statement that stated Resident has Dx(diagnosis) of COPD and is receiving Hospice services with (name of Hospice Agency and phone number). Review of interventions for R38's problem stated of Hospice, dated 07/24/24, did not list the disciplines or frequency of visits for those Hospice services. No documentation was revealed in the chart that demonstrated a coordinated meeting between the Hospice Agency or the facility staff had occurred at the onset of Hospice services. In an interview on 09/19/2024 at 10:26 a.m. Certified Nursing Aide (CNA) Y explained that she knew R38 was on hospice services and the aide comes in on Fridays. CNA Y demonstrated a Hospice Notebook that was kept at the Nurses Station. A Calander of aide visits was observed in the notebook. No other discipline visits were observed on the Calander. No Hospice Plan of care was observed in the Hospice Notebook. CNA Y could demonstrate what services the hospice aide provided to R38 but did explain that after the hospice aide provided care to R38 they would tell the facility CNA's. CNA Y explained that the Hospice Aides have told her when they had provided Activities of Daily Living (ADL) task but did not know where the Hospice Aides documented that care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Nursing and Rehabilitation Community	575 N Madison St Marshall, MI 49068

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/19/2024 at 10:41 a.m. Assistant Director of Nursing (ADON) C explained that if a Resident is receiving hospice care, then a Hospice Notebook would be present at the Nurses station. ADON C explained that a Calander would be present that demonstrated the discipline of services and the frequency of those Hospice services would be present in the Hospice Notebook. ADON C explained that a Hospice plan of care would also be in the Hospice Notebook. ADON C was asked to review R38's Hospice Notebook. ADON C could not demonstrate a plan of care for R38 and could not provide any other disciplines Calendar of visits besides the Hospice Aide. ADON C could not explain why the Hospice Calendars were not present in the notebook and why the hospice plan of care was not in the notebook. In an interview on 09/19/202 at 11:01 p.m. Social Woker (SW) G explained that coordination of care with Hospice Services is a collaborative task with all of the facility staff. She was asked if Hospice had attended a care conference at the start of R38's Hospice care and she responded that she would have to locate the documentation of that care conference. She confirmed that no proof of a care conference with hospice services was present in R38's medical record at this time. In an interview on 09/19/2024 at 12:13 a.m. Social Worker (SW) G demonstrated paper documentation dated 08/28/24 of a care conference that had been conducted with the Hospice agency. SW G explained that she had not loaded the document into R38s' medical record but could not explain the delay. SW G could not explain why the initial care conference for Hospice Services was not performed closer to the start of Hospice care on 07/08/2024.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 49 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 09/18/24 at 04:44 P.M., An environmental tour of the facility Laundry Service was conducted with Director of Maintenance L. The following items were noted: Clean Laundry Room: The flooring surface was observed heavily soiled with accumulated and encrusted dust/dirt deposits. Soiled Laundry Room: The flooring surface was observed heavily soiled with accumulated and encrusted dust/dirt deposits. Director of Maintenance L indicated he would have housekeeping staff thoroughly clean and sanitize the flooring surfaces as soon as possible. Clean Laundry Storage Room: 2 of 2 overhead light plastic lens covers were observed soiled with dead insect carcasses. On 09/19/24 at 08:29 A.M., A common area environmental tour was conducted with Director of Maintenance L. The following items were noted: [NAME] (South): Bath/Shower Room: The atmospheric vacuum breaker was observed missing from the shower wand assembly. Director of Maintenance L indicated he would have staff make necessary repairs as soon as possible. Nursing Station: 2 of 2 chairs were observed (etched, scored, particulate), exposing the inner Styrofoam padding. The chairs could no longer be effectively cleaned and/or sanitized. Janitor Closet: The return-air-exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits. Director of Maintenance L indicated he would have housekeeping staff thoroughly clean the ventilation grill as soon as possible. [NAME] (North): Shower Room: The return-air exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits. Nursing Station: 1 of 2 chairs were observed (etched, scored, particulate), exposing the inner Styrofoam padding. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Forest Hall: Beauty Shop: The chrome plated cosmetology chair base was observed severely corroded and etched. Director of Maintenance L stated: I will have to replace the chair. Soiled Linen Room: The return-air-exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits. Bath/Shower Room: 1 of 4 overhead light assemblies were observed non-functional. Nursing Station: 1 of 2 chairs were observed (etched, scored, particulate), exposing the inner Styrofoam padding. The black plastic resin back support frame was also observed heavily soiled with dust and dirt deposits on the cleanable/sanitizable chair. Dining Room: 1 of 6 tables were observed missing a leg support leveler. 3 of 8 overhead light assembly bulbs were observed secured with nylon zip ties. On 09/19/24 at 10:45 A.M., An environmental tour of sampled resident rooms was conducted by this surveyor. The following items were noted: 101: The flooring surface was observed soiled with accumulated dust, dirt, debris. The perimeter drywall surfaces were also observed (etched, scored, particulate) in numerous locations. The Bed A overbed light assembly actuating pull string extension was additionally observed missing. No toilet tissue was further observed within the wall mounted restroom dispenser. Two empty toilet tissue cardboard rolls were also observed resting on the wall ledge, directly beneath the toilet tissue dispenser. 106: The Bed A and Bed B overbed light assembly night light bulbs were observed non-functional. 109: Two 24-inch-wide by 48-inch-long acoustical ceiling tiles were observed stained from previous moisture exposure. The Bed B bedside table surface was also observed heavily soiled with accumulated and encrusted food residue. The restroom flooring surface was additionally observed soiled with bodily fluids, adjacent to the commode. The restroom was further observed extremely malodorous. No toilet tissue was also observed within the wall mounted restroom dispenser. 111: The restroom commode base caulking was observed (etched, scored, stained). 202: The restroom commode base caulking was observed (etched, scored, stained). The restroom was also observed extremely malodorous. 205: The restroom commode base caulking was observed (etched, scored, stained). 206: The restroom commode base caulking was observed (etched, scored, stained). 210: The restroom commode base caulking was observed (etched, scored, stained). The drywall surface was also observed (etched, scored, particulate), adjacent to the Bed A headboard. The damaged drywall surface measured approximately 3-feet-wide by 4-feet-long. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	214: The commode base caulking was observed (etched, scored, stained). The flooring surface was also observed scuffed with black marks sporadically throughout the resident room. 216: The restroom commode base caulking was observed (etched, scored, stained). The restroom overhead light plastic lens cover was also observed soiled with dead insect carcasses (3). The overhead light assembly plastic lens covers (2) were additionally observed soiled with dead insect carcasses. The Bed B master bed control electrical feed wire insulation was further observed frayed, exposing the inner electrical wires. Director of Maintenance L stated: I can wrap the cord with black tape, until the new control is available. 218: The Bed B television electrical feed cord was observed missing, creating a non-functional television set. The drywall surface plastic protection panel was also observed loose-to-mount, adjacent to the Bed A headboard. The Bed A overbed light assembly pull string actuator cord was additionally observed missing. On 09/20/24 at 12:30 P.M., Record review of the Maintenance Request Logs for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns. On 09/20/24 at 12:45 P.M., Record review of the Policy/Procedure entitled: Housekeeping Cleaning Schedules dated (no date) revealed under Policy: It is the policy of this facility to ensure residents live in a safe, clean, and sanitary environment and that staff are available to meet this need. Record review of the Policy/Procedure entitled: Housekeeping Cleaning Schedules dated (no date) further revealed under Procedure: (4) The Maintenance Director or Designee monitors for compliance utilizing the work order notification process as well as verbal notification. On 09/20/24 at 01:00 P.M., Record review of the Policy/Procedure entitled: Overview Maintenance Services dated (no date) revealed under Policy: It is the policy of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Record review of the Policy/Procedure entitled: Overview Maintenance Services dated (no date) further revealed under Procedure: (1) The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner. On 09/20/24 at 01:15 P.M., Record review of the Policy/Procedure entitled: Cleaning and Disinfecting Resident's Room dated (no date) revealed under Policy: To provide guidelines for cleaning and disinfection of resident's room to ensure sanitary conditions are maintained, to assist in preventing the spread of disease-causing organisms by keeping resident care equipment clean. Record review of the Policy/Procedure entitled: Cleaning and Disinfecting Resident's Room dated (no date) further revealed under Procedure: (1) Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. (2) Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.