STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235175	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 This citation pertains to Intake Numbers MI00141996 and MI00143446. Based on observation, interview and record review, the facility failed to have call lights within reach or respond to in a timely manner for three residents (Resident #6, Resident #15, Resident #200) and one resident (Resident #100) being left exposed, in a review of 12 residents reviewed for dignity, resulting in residents verbalizing complaints, frustration, and likelihood for mental anguish. Findings include: Record review of the facility 'Promoting/Maintaining Resident Dignity' dated 10/26/2023 revealed it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Record review of the facility 'Resident Rights' policy dated 1/1/2022 revealed employees shall treat residents with kindness, respect, and dignity. Record review of the facility 'Call Lights: Accessibility and Timely Response' policy dated 12/28/2023 revealed the purpose of the policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. (1.) Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light. On 4/30/2024 at 2:00 PM, Resident Council was held with twelve facility residents. Residents were asked about facility call light response times and the following was reported: - Attendee #1: They have brought timeliness of call light response up in the past and while changed for a short time it reverted back to waits over 30 minutes. - Attendee #2: They waited over an hour and went to the nurse's station to find their aide to get their need meet. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Attendee #3: It's inconsistent on if they will answer the light timely and it's across all shifts. - Attendee #4: They waited an hour recently for staff to assist them to the restroom. - Attendee #5: It's takes staff over an hour to answer their light 7 of 12 residents reported they wait over 30 minutes for their lights to be answered. Resident #15: Observations on 04/29/24 at 02:31 PM with Certified Nurse Assistant (CNA) A was asked by the state surveyor to enter with the surveyor into Resident #15's room where the call light was coiled up and clipped to the wall call light unit out of reach of the resident. CNA A stated that Resident #15 does communicates she does talk, but she has certain words such as food, potty, basic words. The state surveyor and CNA observed the call light curled up and clipped to the wall unit. CNA A stated that she did not have the resident today, but that CNA B had her that day. Observation on 04/30/24 at 02:17 PM the state surveyor observation of Resident #15's room, revealed the call light was clipped to the wall again. The CNA C came into the room as the surveyor was standing in the open doorway, the state surveyor asked why the call light was over behind an extra straight back chair located in the room? The CNA C came into the room picked call light from bedside chair in the A-bed area of the room and then placed the call light within reach of the resident. Resident #100: Observation on 04/29/24 at 02:28 PM by the state surveyor while touring the [NAME] Hall unit revealed that Resident #100 in room [ROOM NUMBER] with the door wide open. The Resident #100 was observed lying in bed in a mint green brief with his legs and belly exposed to all staff and visitors that pass by the room. The mint green disposable brief was rumpled and wet. There was no sheet or blanket within reach of the resident. Resident #200: Observation on 05/01/24 at 10:04 AM with Licensed Practical Nurse (LPN) D the Resident #200 was taken to his room by CNA A from dining room and had passed by the nurse and state surveyor in the [NAME] hallway an estimated 5 to 10 minutes prior. Observation of Resident #200 seated up in wheelchair on the right side of the bed near the intravenous medication pole and the call light was left on the bed out of reach of resident on the left side of the bed. The state surveyor asked why the call light was left on the left side of the bed when the resident was seated on the right side of the bed out of reach. LPN D stated that it should not be on that side of the bed when he is over here on the window side of the bed. 39059 Resident #6: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/24, at 9:18 AM, Resident #6's call light was visibly activated with the outside hall light on. The call light remained on until 9:27 AM with no staff entry into the room. On 4/29/24, at 9:27 AM, Resident #6 was lying in their bed and offered they wanted to get up out of bed. On 4/28/24, at 9:40 AM, CNA K entered and confirmed that Resident #6 wanted to get up. CNA K left out to go get help. On 4/28/24, at 9:43 AM, CNA K and CNA B entered the room and offered Resident #6 assistance on getting up out of bed. On 5/01/24, at 9:18 AM, CNA K was interviewed regarding Resident #6's needs on the morning of 4/29. CNA K offered that they were assisting with another resident shower knew Resident #6 wanted to get up but then had to assist two other residents with their breakfast meals first.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to follow the standards of practice for administration of oral Coumadin anti-coagulant and intravenous Vancomycin antibiotic medications for two residents (Resident #100, Resident #200), resulting in an excessive dose of Coumadin anti-coagulant and intravenous Vancomycin antibiotic medications therapy with the likelihood for prolonged illness and/or hospitalization . Findings include: Record review of facility 'Admission Contract' page 8 of 12, section 13.2 Nursing staff (licensed nurses and nurse aides) work in the Center seven days a week, 24-hours a day. These staff are assigned to provide the reasonable and customary nursing home nursing and personal care. The services of the Nursing Department are provided under the supervision of a Director of Nursing or his/her designee. Record review of the American Nurses Association (ANA) statement of The Standards of Practice describes a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. Nursing: Scope and Standards of Practice, Third Edition, guides nurses in the application of their professional knowledge, skills, and responsibilities. https://www.nursingworld.org Record review of the 'Nursing 2017 Drug Handbook' page 1512-1515, revealed Coumadin anticoagulant with oral administration draw blood to establish baseline coagulation parameters before therapy. Protime (PT) and International Normalization Ratio (INR) determinations are essential for proper control. Recommended INR range is usually 2 to 3 for most patients. Nursing considerations: Black Box Warning- Coumadin can cause major or fatal bleeding . Regularly monitor International Normalization Ratio (INR) in all patients. Resident #100: Record review of Resident #100's admission Minimum Data Set, dated dated dated [DATE] revealed an elderly resident with medical diagnosis of: Atrial fibrillation, heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, benign prostatic hyperplasia, diabetes, thyroid disorder, arthritis, and malnutrition. Section N: High Risk Medications: Anticoagulant, Antibiotic, Diuretic, Opioid, Antiplatelet, Hypoglycemic (Insulin). Record review of Resident #100's April 2024 Medication Administration Record (MAR) noted: PT and INR one time a day every Monday, Wednesday, Friday related to Chronic Diastolic (Congestive) Heart Failure start date 4/22/2024 scheduled at 5:00 AM. Record review of the PT/INR order noted blank MAR days on 4/22/2024, 4/26/2024, and 4/29/2024. Record review of Resident #100's Progress notes dated 4/22/2024 through 4/30/2024 revealed that on there was documentation of the nurses monitoring the PT/INR laboratory results. Record review of Resident #100's Nurse Practitioner progress note dated 4/24/2024 at 00:00 telehealth visit/note noted INR 3.66 Coumadin 2 mg given. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/24 at 12:22 PM with Nurse Practitioner (NP) J reviewed the PT/INR lab results of elevated values and stated per nursing policy the facility checks PT/INR three days a week. The NP had a discussion with her supervisor and we to hold the Coumadin from 4/27/24 through 4/29/2024 when the next lab results of the next draw come back. We are giving the medication Coumadin for atrial fibrillation for clot prevention. Therapeutic INR level goal was to be between 2 and 3. In an interview and record review on 05/01/24 at 01:05 PM with Licensed Practical Nurse (LPN) LPN/Unit Manger F of Resident #100's Coumadin anti-coagulant (Blood thinner) 2.5 mg oral every day at 9:00 PM, LPN/Unit Manager F stated that the PT/INR is used for their blood bleeding time, we don't want them to thin, we would hold the Coumadin if the level is too high. Record review of Resident #100's April 2024 Medication Administration Record (MAR) revealed that the PT/INR was not being documented on the MAR record consistently. The surveyor stated that the Coumadin is a Black box high risk medication. The LPN/Unit Manager F stated that she would not give the Coumadin unless she knew what was that PT/INR levels. That it was a nursing standard of practice. Record review of the April 2024 Medication Administration Record revealed that on 4/26/2024 at 9:00 PM the medication dose was given. Record review of Resident #100's laboratory blood work results on 4/26/2024 at 9:04 AM revealed PT/INR 35.6/3.58 (high levels). on 4/27/2024 the provider was notified, and the medication was held. Coumadin is an anti-coagulant/blood thinner; it can cause bleeding if levels are elevated. Resident #200: Record review of Resident #200's April 2024 Medication Administration Record (MAR) revealed that the resident was Vancomycin 750 mg/250 ml solution antibiotic intravenous. Record review of LabCorp http://www.labcorp.com identified Vancomycin trough concentrations are recommended for therapeutic monitoring of Vancomycin antibiotic. To avoid the development of resistance, Vancomycin trough levels should remain above 10.0 mcg/ml. Complicated infections require higher target levels, typically 15.0 to 20.0 mcg/ml. Record review of Resident #200's April medication Administration Record (MAR) revealed that Vancomycin 750 mg/250 ml solution was discontinued on 4/30/2024 at 11:22 AM by licensed Practical Nurse (LPN) D. In an interview and observation on 5/1/2024 during the medication pass task in estimated at 9:30 AM while in Resident #200's room with the intravenous medication pole observed an empty Vancomycin 750 mg/250 ml solution bag still hanging at bedside. LPN D stated that she worked on 4/30/2024 and looked up the Vancomycin trough lab values and change the dose/strength via pharmacy dosing. No, the night shift nurse should not have hung the evening dose of Vancomycin 750 mg dose on the 4/29/2024, it should have been the 500 mg/100 ml. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 05/01/24 at 12:46 PM with Licensed Practical Nurse (LPN)/Unit manager F of Resident #200's antibiotic Vancomycin 750/250 ml twice daily, that order changed on 4/30/24 morning by LPN D day shift nurse. Because the trough was elevated 20.9 that is elevated therapy value. The Registered Nurse P reviewed the April Medication Administration (MAR) had a nurse on orientation hang the 750 mg/250 ml bag, that is a huge problem. The lab value on 4/29/2024 was available at 9:28 AM, with an elevated trough of 20.9. Record review of the 8:00 PM dose of 750 mg was hung by night shift LPN even though the Vancomycin antibiotic order had been changed to Vancomycin 500 mg/100 ml twice daily intravenous. LPN/Unit Manager F stated that she would not hang Vancomycin antibiotic if she did not now the trough levels.

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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** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures to ensure timely completion and assessment of diagnostic/laboratory testing as well as comprehensive assessment, monitoring, and treatment following a change in condition for two residents (Resident #49, and Resident #100) reviewed, resulting in a lack of laboratory monitoring of medications for Resident #100 and Resident #49 experiencing a change in condition, a lack of comprehensive assessment, laboratory testing/results, and resident involvement in care decisions. Findings include: Resident #49: Record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses which included Covid-19, pneumonia, Congestive Heart Failure (CHF), and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was [AGE] years old, cognitively intact, and required supervision to moderate assistance to complete Activities of Daily Living (ADL). Resident #49 passed away in the facility on 2/22/24. Per the Electronic Medical Record (EMR), Resident #49 signed a Do Not Resuscitate (DNR) form on 2/14/24 which detailed they did not want to be resuscitated in the event that their heart and breathing should cease. The form did not specify any other wishes related to medical treatment and/or hospitalization . Resident #49 made their own medical and financial decisions. Review of Resident #49's EMR documentation revealed the Resident was admitted to the facility following hospitalization for pneumonia and hypoxia (decreased oxygen in blood) for rehabilitation. Per the Hospital Discharge Summary dated 2/9/24, a Covid test was requested by the nursing facility prior to hospital discharge. The Covid test was positive, and Resident #49 was discharged to the facility in improved condition with orders for a 10-day course of oral steroid therapy. The Discharge Summary included Physician assessment documentation indicating Resident #49 had diminished left lobe lung sounds with improved rhonchi (abnormal lung sounds usually caused by obstruction of larger airways by secretions/fluids and/or inflammation). Review of documentation in Resident #49's EMR detailed the following: - 2/12/24: Nurse Practitioner Progress Notes: Establish Care . found to be Covid positive and transferred to this facility for further medical care, rehab, and quarantine. This morning patient is in no acute distress . does admit to a mild cough but is maintaining oxygen saturations greater than 90% on low-flow O2 (oxygen) . denies any chest pain, shortness of breath or nausea or vomiting . will begin working with physical therapy today . Physical Exam . Respiratory . (lung sounds) CTA (Clear to Auscultation) . Baseline labs ordered . - 2/15/24 at 2:54 PM: IDT-Interdisciplinary Progress Note . Continues on PT (Physical Therapy) and OT (Occupational Therapy). Is ambulating 10' (feet) 2WW (wheeled walker) CGA (contact guard assist), transfers are mod (moderate assist), UB (Upper Body) set up and LB mod . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/16/24 at 3:52 PM: Covid Skilled Note . O2 (oxygen) sats: 99% . Room Air . List present signs or symptoms of Covid-19 . Malaise/Fatigue . - 2/16/24 at 5:26 PM: Nurses' Notes . refused morning medication per previous shift and has refused bs (blood sugar) for lunch and dinner notified on call (provider). - 2/16/24 at 11:57 PM: Covid Skilled Note . O2 (oxygen) sats: 99% . Room Air . List present signs or symptoms of Covid-19 . Cough . - 2/17/24 at 7:47 PM: Covid Skilled Note . O2 (oxygen) sats: 96% . Oxygen via Nasal Cannula . List present signs or symptoms of Covid-19 . Cough . Malaise/Fatigue . - 2/19/24: Nurse Practitioner Progress Notes: Follow up . seen today to follow-up on Covid infection. Patient has developed a loose cough . lungs exhibit loose rhonchi (abnormal lung sounds usually caused by obstruction of larger airways by secretions/fluids and/or inflammation) . oxygen dependent maintaining oxygen saturations however due to advanced age is at risk for rehospitalization . I have ordered a chest x-ray for further evaluation. I have initiated Rocephin (antibiotic) 1g (gram) twice daily today and I will follow-up with results of the chest x-ray . Foley (indwelling urinary) catheter is draining clear yellow urine . Assessment and Plans . Patient has now developed adventitious lung sounds . is maintaining oxygen saturations on O2 therapy. Chest x-ray ordered. 1 g of Rocephin every 12 hours today has been ordered . Suspected recurrent Covid-pneumonia . - 2/19/24: Nurse Practitioner Progress Notes: Follow up . seen today to follow-up on chest x-ray . Chest x-ray was reviewed and noted for interstitial pneumonitis along with congestive heart failure . has been started on Levaquin (antibiotic) course secondary to chest x-ray result . does have loose rhonchi . oxygen dependent maintaining oxygen saturations . - 2/19/24 at 5:06 PM: Covid Skilled Note . O2 (oxygen) sats: 98% . Trach (Note: Resident did not have a tracheostomy- surgically created airway through a hole in the front of the neck to the trachea) . List present signs or symptoms of Covid-19 . Cough . Loss of appetite . Shortness of Breath . - 2/20/24 at 1:11 PM: Covid Skilled Note . O2 (oxygen) sats: 90% . Room Air . List present signs or symptoms of Covid-19 . None . - 2/20/24 at 5:51 PM: Nurses' Notes . Resident . transferred to general population (from Covid isolation). Resident is alert and oriented x 3 (Person, Place, and Time) . - 2/20/24 at 2:48 PM (Lock Date: 2/22/24 at 2:51 PM): Skilled Daily- Medically Complex . Orientated to: Person, Place . Most Recent Blood Pressure . 101/56 . Date: 2/22/24 at 12:54 . Respiratory . Not experiencing SOB (Shortness of Breath) . Respiratory Items in use: Oxygen therapy . Respiratory Medications . Is oxygen titration being attempted? No . Most Recent O2 Stats . 90% . Room Air (no supplemental oxygen in place) . Date: 2/22/24 12:54 . Any new labs and/or tests ordered this review period? No . Any new labs and/or tests completed this review period? No . Was MD/Practitioner notified of any changes, abnormal vital signs, and/or test/lab results this review period? No . - 2/21/24: Nurse Practitioner Progress Notes: Follow up .seen today to f/u (follow up) on covid and pneumonitis. Patient is on antibiotic therapy and o2 at 2L (liters) n/c (nasal cannula) . lung sounds are improving . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/21/24 at 4:20 PM: Pertinent Charting-Change in Condition . accessory muscles used to breathe, medications needed to be crushed as resident was unable to swallow pills during AM meds. Resident had discolored urine in catheter bag and blood-tinged urine with pus . Nursing intervention: UA (Urinalysis) completed. Started on prednisone (steroid medication) 20 mg (milligrams) x 5 days daily. New catheter replaced to obtain urine specimen . Notification: (Nurse Practitioner S) . Resident is responsible for self. Spoke with (Family Member) . - 2/21/24 at 4:27 PM: Nurses' Notes . Catheter system changed to obtain sterile specimen. Blood-tinged urine, with mucus and foul odor present. Resident was uncomfortable during this time, having facial grimacing . - 2/22/24: Nurse Practitioner Progress Notes: Follow up . seen today to follow-up on pneumonia . was started on antibiotic therapy a couple days ago secondary to pneumonia . also started on prednisone therapy . was noted to be hypotensive (low blood pressure- less than 90/60) . is having an overall decline in status . is DNR . do have a UA with culture pending secondary to significant sediment in Foley catheter drainage bag. Repeat labs are pending. Patient is afebrile (no temperature) . is having some difficulty maintaining oxygen saturations greater than 90% on 5 L of oxygen. Nursing was instructed to provide a nebulizer this morning to patient. I did have an opportunity to speak with (Family Member T) this morning . does not want patient sent out to the hospital . Exam Findings . Appears comfortable . PERRLA (Pupils Equal Round and Reactive to Light and accommodation -normal) . Exam Findings . Appears comfortable . Respiratory . (lung sounds) CTA . Behavior . Positive: Cooperative . Vital Signs . Blood Pressure: 99/49 . Oxygen Saturation: 92% . Laboratory: Repeat (blood tests) ordered . Encounter for palliative care . discussion with (Family Member T), comfort measures only . - 2/22/24 at 12:00 PM: Nurses' Notes . writer and other nurse on duty went in to provide care to resident. During this time resident refused to take oral medications . This writer asked if would like hospice services. Resident declined. This writer asked if (family) aware of wishes in response resident stated yes . Informed Nurse Practitioner S . did state that there was a conversation held today with (Family Member T) and bringing up POA (Power of Attorney) paperwork . - 2/22/24 at 3:43 PM: Nurses' Notes . CNA (Certified Nursing Assistant) alerted this writer at approx. 1430 (2:30 PM) that resident appeared to not be breathing. This writer and other nurse on duty each listened to apical pulse for a full minute each. Resident had lack of all VS (vital signs) . Review of Resident #49's Health Care Provider orders in the EMR revealed the following: - Oxygen: Run at 5L (Liters)/Min via N/C (nasal cannula) . PRN (as needed) . every shift . (Ordered: 2/12/24) - CBC (Complete Blood Count -blood test) . A1C (hemoglobin A1C- blood test that measures average blood sugar levels over previous 3 months)/CMP (Complete Metabolic Panel -blood test) one time only for new admit (Ordered: 2/11/24) - CBC/CMP one time only for Monitoring for 2 Days (Ordered: 2/19/24) - CBC and CMP one time only for Monitoring for 2 Days (Ordered: 2/22/24) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prednisone . 5 mg (milligram) . one tablet by mouth one time a day . related to pneumonia . (Start Date: 2/11/24; Discontinued: 2/22/24) - Prednisone . 5 mg (milligram) . one tablet by mouth one time a day for corticosteroids for 5 Days . (Start Date: 2/22/24) - Ceftriaxone Sodium (Rocephin - antibiotic) Solution Reconstituted 1 gram . intramuscularly (IM) two times a day for Pneumonia for 1 Day (Ordered: 2/19/24; Discontinued: 2/20/24) - Levaquin (antibiotic) Tablet 500 mg (milligram) . 1 tablet by mouth one time a day for infection- covid pneumonia for 7 Days (Start Date: 2/20/24) - Ipratropium-Albuterol Solution (Duoneb breathing treatment) 0.5-2.5mg/3 mL (milliliter) . inhale orally four times a day for SOB (shortness of breath) . (Ordered: 2/21/24) There was no active, completed, discontinued, on-hold, pending, and/or struck out orders for a Urinalysis nor was there an order to titrate Resident #49's oxygen administration rate. Review of Resident #49's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for February 2024 revealed the Resident received Rocephin (antibiotic) 1 gram IM one time on 2/19/24. A review of Resident #49's vital sign documentation in the EMR revealed: - Resident #49's oxygen saturation varied from 90 to 99% during their stay at the facility and did not consistently have supplemental oxygen in place regardless of oxygen saturation. The documentation detailed the Resident was on room air as well as with supplemental oxygen via nasal cannula (with no documented rate) and trach. - Resident #49's blood pressure documentation revealed their diastolic (lower number) blood pressure was less than 60 (hypotensive criteria), eight times during their stay at the facility on 2/13/24 at 4:13 AM, 2/13/24 at 5:53 PM, 2/14/24 at 3:15 AM, 2/14/24 at 6:00 AM, 2/14/24 at 11:47 AM, 2/21/24 at 3:59 AM, 2/22/24 at 9:05 AM, and 2/22/24 at 12:54 PM. There was no documentation of re-evaluation/re-assessment of any of the hypotensive blood pressure measurements/abnormal vital signs. The only laboratory testing results in Resident #49's EMR were dated as collected on 2/12/24. A chest day dated as completed on 2/20/24 was also present in the EMR. Further review of Resident #49's EMR revealed the Resident had Durable Power of Attorney (DPOA) documentation dated 9/26/16. The document was scanned into the Resident's EMR following their death in the facility. The document detailed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Designation of Patient Advocate . Durable Power of Attorney for Health Care and for Care, Custody, and Medical Treatment Decisions of (Resident #49) . 1. I designate (Family Member T) as my agent and advocate to act under this instrument accordance with the provisions set forthwith . 3. Disability of Principal. This Durable Power of Attorney for Healthcare for Care, Custody, and Medical Treatment Decisions shall become effective only upon my disability as determined by my attending physician and another physician or licensed psychologist and shall not be affected by my disability or incompetence . 7. Statement of Philosophy, I enjoy and value my life. I do not want my life to end, but I also recognize and accept the fact of my own mortality. I do not seek to die, but I do not want my life to be prolonged or my death to be postponed in all circumstances. Accordingly, I have caused this document to be prepared to express my wishes and instructions concerning my medical treatment. I believe that I have a right to self- determination and a constitutional right of privacy, and a constitutional right to liberty, all of which give me the power to decide what should and what should not be done to my body. I understand that these rights are not absolute, and that their exercise may be limited by the state in certain circumstances. I do not want the exercise of my rights ever to be frustrated or limited because of any uncertainty about my wishes or about what actions I believe will be in my best interests. I urge my family, my friends, my treating physicians, and any hospital, nursing home, hospice or other health care facility involved in my care as a patient, to accept and rely upon this document as clear and convincing evidence of how I want my rights of self-determination and privacy to be exercised in making medical treatment decisions about me, should I be unable to express my desires myself because of illness, disease, infirmity, injury or any other cause. 8. Instructions & Desires Regarding Medical Treatment. I do not wish to receive or to continue to receive medical treatment which will only postpone the moment of my death from an incurable and terminal condition, or which will prolong an irreversible loss of awareness, irreversible coma or persistent vegetative state . On 5/1/24 at 5:00 AM, an interview was conducted with Nurse W. When queried regarding Resident #49, Nurse W revealed the Resident had been transferred from the Covid isolation unit to a regular unit of the facility. When asked what they recalled about the Resident, Nurse W stated, (Resident #49) was talking and alert and was smiling and happy on 2/20/24. Nurse W was asked about the Resident's cognitive status and revealed the Resident was cognitively intact and able to make their own decisions. When asked what happened, Nurse W revealed Resident #49's condition declined overnight following their transfer out of the Covid isolation unit of the facility. When asked if the Health Care Provider had been notified, Nurse W confirmed they were and revealed they thought the Resident needed to be shipped to the hospital but (Nurse Practitioner S) did not want to transfer the Resident. An interview was conducted with Infection Control Registered Nurse (RN) V on 5/1/24 at 8:27 AM. When queried regarding Resident #49, RN V reviewed the Resident's EMR and indicated they did. When queried what occurred during their stay at the facility, RN V stated, Came in on February 10th for Covid. They started developing a loose cough on 2/19, a chest x-ray was ordered, and they received Rocephin. RN V revealed the Resident was started on Levaquin oral on 2/20/24. RN V was then asked about Resident #49's death in the facility and stated, By the 22nd, they started to decline and their (supplemental) oxygen was increased to 5 liters. When asked, RN V verbalized the Resident's family did not want them sent to the hospital per the provider note. When queried regarding the results of the completed UA as indicated in the nursing documentation, RN V revealed they were unable to locate any UA results in the EMR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 5/1/24 at 10:33 AM. When queried regarding Resident #49, the DON replied that the Resident had passed away. When queried when the Resident was last seen prior to being found in their room by staff, the DON was unable to provide a specific time. When asked why the Resident was moved rooms on 2/20/24, the DON revealed the Resident was moved out of Covid isolation unit of the facility. When queried regarding facility documentation and assessment when a Resident has a change in condition, the DON indicated a change in condition and SBAR assessment documentation are completed. When asked why a change in condition and/or SBAR assessment was not completed on 2/19/24 related to documentation of altered lung sounds and a loose cough by the physician, the DON stated, We don't do a change in condition on a Covid patient. When asked why they do not, the DON did not provide a response but indicated Residents who are Covid-positive tend to be sicker with more changes than other facility residents. When queried regarding nursing assessment of Resident #49's lung sounds and what the change in their cough was around on 2/19/24, the DON verified lack of nursing physical assessment documentation including lung sounds and cough characteristics/change but did not provide further explanation. When queried if the resident was admitted to the facility on prednisone, the DON reviewed the EMR and confirmed they were. The DON was then asked about the Health Care provider note, dated 2/22/24, indicating Resident #49 was started on prednisone on that date, the DON was unable to provide an explanation. When queried why Resident #49 was not started on Duoneb breathing treatments until 4/21/24 at 6:00 PM when they were suspected of having pneumonia on 2/19/24, the DON revealed breathing treatments were not initiated until the Resident was moved out of the Covid isolation unit of the facility. The DON was asked when Resident #49 was moved out of the Covid isolation unit of the facility, the DON replied, On 2/20. No further explanation was provided. When queried if Resident #49 had a UA on 2/21/24, the DON reviewed the documentation and indicated it was documented as completed. When queried regarding the results, the DON revealed they were unable to locate the UA results in the EMR. The DON indicated they were going to check to see if it had not been scanned into the EMR and left the room. Upon returning to the room, the DON stated they could not find the UA. The DON was then asked why there was no order for the UA and if it had ever been completed, the DON did not provide a response. The DON then revealed the only staff member able to access the online laboratory portal for results was Unit Manager Licensed Practical Nurse (LPN) F and they would have them obtain the results. When queried regarding the results for the laboratory blood testing ordered on 2/19/24 and 2/22/24, the DON confirmed the results were not in the EMR and indicated they would also have Unit Manager LPN F obtain them. When asked if Resident #49 made their own medical decisions, the DON replied that they did. When asked if the Resident had been deemed incompetent, the DON stated, No. The DON was then asked why Family Member T made the decision to not have Resident #49 transferred to the hospital without their input, the DON specified Family Member T was the Resident's emergency contact. The DON then provided an Advance Care Planning note dated 2/15/24 which detailed that Resident #49 states that in the event of an emergency, they would like for the following individuals to make medical decisions for them. They state that this person is aware of their advance directives . Family Member T was not listed under the paragraph. Their name was listed above the statement under Emergency Contacts Present. An interview was conducted with Unit Manager LPN F and the DON on 5/1/24 at 11:09 AM. When queried regarding Resident #49's blood laboratory testing and UA results from 2/19/24, 2/21/24, and 2/22/24, LPN F reviewed the online laboratory results system and stated, No labs obtained. When queried if the laboratory testing was completed, the DON stated, I do not have an answer and Unit Manager LPN F stated, I am not sure. Unit Manager LPN F revealed they would contact an individual from the laboratory company and provide any documentation received. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 11:30 AM, an interview was completed with LPN E. When queried regarding Resident #49, LPN E revealed they were the Resident's assigned nurse on the day they passed. When queried what occurred, LPN E stated, (Resident #49) was fine then overnight was different. LPN E stated, I thought (Resident #49) needed to be shipped (to the hospital). I told (Nurse Practitioner S) right away but I can't overgo the doctor. When asked to explain, LPN E revealed Nurse Practitioner S said they spoke to the Resident's family, and they did not want the Resident sent to the hospital. When queried regarding Resident #49's condition on the morning of 2/22/24, LPN E stated, That morning (Resident #49) was not that talkative but was still answering questions. With further inquiry, LPN E revealed Resident #49 was normally very talkative and pleasant. LPN E was asked if Resident #49 was responding to questions appropriately on 2/22/24 and replied that they were. LPN E was asked if Resident #49 had ever told them they did not want to go to the hospital for treatment and revealed they had not. When queried if Resident #49 was eating and drinking, LPN E stated, Not so much. When asked to clarify, LPN E revealed the Resident did not seem to have much of an appetite. When queried regarding their output, LPN E indicated they did not recall. When asked, LPN E revealed they were notified by a Certified Nursing Assistant (CNA) that Resident #49 was not breathing. LPN E was asked when they had last seen the Resident prior to the CNA coming to tell them that and stated, I can't say for sure. (Resident #49) was using their accessory muscles (to breath) and it was definitely a change. LPN E verbalized they informed Nurse Practitioner S of the change in Resident #49's condition and their concern regarding the need for emergency medical treatment. An interview was conducted with Nurse Practitioner S on 5/01/24 at 1:01 PM. When queried if they recalled Resident #49, Nurse Practitioner S indicated they were contacted by facility Administration and had reviewed the Resident's EMR. Nurse Practitioner S was then queried regarding Resident #49's medical condition and care while at the facility. Nurse Practitioner S revealed the Resident was admitted to the facility for rehabilitation following hospitalization for Covid pneumonia. When queried if the Resident was treated for Covid at the hospital or the Resident tested positive for Covid at the time of discharge, Nurse Practitioner S did not provide a response. When queried regarding Resident #49's chest x-ray and subsequent pneumonia diagnosis on 2/19/24, Nurse Practitioner S confirmed and indicated the pneumonia was related to Covid infection. Nurse Practitioner S then stated they Spoke to (Family Member T because (Resident #49) was not improving. When asked why they did not transfer the Resident to the hospital, Nurse Practitioner S stated, (Resident #49) was 96 (years old) and a DNR. When queried why they did not send the Resident to the hospital sooner, Nurse Practitioner S indicated they were treating the Resident at the facility. When queried if the Resident had advance directives specifying no hospitalization , Nurse Practitioner S did not respond to the question but reiterated they spoke to Resident #49's family member. When queried if they asked Resident #49 if they wanted to go to the hospital for treatment, Nurse Practitioner S stated, No. Nurse Practitioner S was asked why they did not ask the Resident and replied there was documentation in the EMR that Family Member T was able to make medical decisions in an emergency. Nurse Practitioner S was then asked if the Resident was alert and able to speak and indicated any assessment documentation would be in their notes in the EMR. When asked why there was no documentation indicating the Resident was no longer able to verbalize their wishes regarding care, an explanation was not provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked what defines an emergency for which a family member is able to make medical decisions for a Resident per the Advanced Care Planning progress note, Nurse Practitioner S did not provide a clear explanation. When queried if Resident #49 made their own medical decisions, Nurse Practitioner S confirmed the Resident did and had not been deemed incompetent. Nurse Practitioner S was then asked what oxygen flow rate Resident #49 was supposed to be receiving and replied 5 liters via nasal cannula as per their documentation. When asked if nursing staff were supposed to be titrating the oxygen administration rate, Nurse Practitioner S reiterated it was supposed to be at 5L. Nurse Practitioner S was then asked why some documentation in the EMR indicated the Resident was on room air, nasal cannula at 2 liters, nasal cannula at 5 liters, and trach, Nurse Practitioner S was unable to provide an explanation. When queried if they had received the laboratory testing results from the UA indicated in the notes on 2/21/24 and the blood tests ordered on 2/19/24 and 2/22/24, Nurse Practitioner S verbalized they would have documented if they had reviewed the lab results. When queried if they were aware of Resident's decreased intake beginning on 2/19/24, Nurse Practitioner S did not provide a response but referred to their documentation in the EMR. No further explanation was provided when queried regarding Resident #49's care at the facility. Review of Resident #49's Documentation Survey Report for February 2024 revealed the Resident did not have a notable decline in ADL care performance while at the facility. However, Resident #49 refused lunch and supper on 2/19/24 and 2/20/24 and all meals as well as fluid intake on 2/21/24 and 2/22/24. A follow up interview was completed with the DON on 5/1/24 at 2:01 PM. When asked again about Resident #49's labs and UA results, the DON indicated staff were still attempting to locate the results. When queried what constitutes an emergency as specified in the Advance Care Planning Note related to medical decision making, the DON did not provide a clear explanation but indicated they believed a change in condition constituted an emergency. A policy/procedure was requested at this time and the DON verbalized they did not believe the facility had a policy/procedure which defined emergency related to the Advance Care Planning note and when a Resident would like someone else to make medical decisions for them. When queried if the facility should have copies of laboratory testing in the EMR, the DON confirmed they should. When asked how appropriate clinical decisions are made in a timely manner without diagnostic testing results, the DON did not provide an explanation. The DON was then queried regarding Resident #49's decreased intake and if they were having decreased urinary output and stated, We don't monitor the amount of output because this is their home. When queried how they were able to accurately assess and monitor a change in condition and respond appropriately when nursing staff are not completing a comprehensive nursing assessment including auscultation, re-evaluation of abnormal vital signs, and monitoring of urinary output along with oral intake, no further explanation was provided. A policy/procedure related to Advance Care Planning in an emergency was not received by the conclusion of the survey. Upon request for policy/procedure related to change in condition including nursing assessment and documentation, the policy/procedure entitled, Notification of Changes (Reviewed: 1/1/22) was provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy/procedure revealed, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification. Definitions: 'Life-Threatening Conditions': Examples -Heart Attack or Stroke . 'Need to alter treatment significantly' means a need to stop a form of treatment because of adverse consequences, or commence a new form of treatment to deal with a problem . Compliance Guidelines . For changes of condition . 1. SBAR process for assessment, documentation, and report to the practitioner . Sepsis protocols . Circumstances requiring notification include . 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health . Additional considerations: 1. Competent individuals: a. The facility must still contact the resident's physician and notify the resident's representative, if known . c. When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the cause of sudden illness . 22927 Record review of the 'Nursing 2017 Drug Handbook', pages 1512-1515, revealed Coumadin anticoagulant with oral administration draw blood to establish baseline coagulation parameters before therapy. Protime (PT) and International Normalization Ratio (INR) determinations are essential for proper control. Recommended INR range is usually 2 to 3 for most patients. Nursing considerations: Black Box Warning-Coumadin can cause major or fatal bleeding . Regularly monitor International Normalization Ratio (INR) in all patients. Resident #100: Record review of Resident #100's admission Minimum Data Set, dated dated [DATE], revealed an elderly resident with medical diagnosis of: Atrial fibrillation, heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, benign prostatic hyperplasia, diabetes, thyroid disorder, arthritis, and malnutrition. Section N: High Risk Medications: Anticoagulant, Antibiotic, Diuretic, Opioid, Antiplatelet, Hypoglycemic (Insulin). Record review of Resident #100's April 2024 Medication Administration Record (MAR) noted: PT and INR one time a day every Monday, Wednesday, Friday related to Chronic Diastolic (Congestive) Heart Failure start date 4/22/2024 scheduled at 5:00 AM. Record review of the PT/INR order noted blank MAR days on 4/22/2024, 4/26/2024, and 4/29/2024. Record review of Resident #100's Progress notes, dated 4/22/2024 through 4/30/2024, revealed that there was documentation of the nurses monitoring the PT/INR laboratory results. Record review of Resident #100's Nurse Practitioner progress note, dated 4/24/2024 at 00:00 telehealth visit/note noted INR 3.66 Coumadin 2mg given. In an interview on 05/01/24 at 12:22 PM, Nurse Practitioner (NP) J reviewed the PT/INR lab results of elevated values and stated per nursing policy the facility checks PT/INR three days a week. The NP had a discussion with her supervisor and were to hold the Coumadin from 4/27/24 through 4/29/2024 when the next lab results of the next draw come back. We are giving the medication Coumadin for atrial fibrillation for clot prevention. Therapeutic INR level goal was to be between 2 and 3. < [TRUNCATED]

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F 0686 Level of Harm - Minimal harm or potential for 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** 39059 Based on observation, interview and record review, the facility failed to implement interventions timely to prevent an Unstageable (full-thickness pressure injury in which base is covered by eschar and/or slough) Coccyx Pressure Ulcer for one resident (Resident #6), resulting in a new unstageable pressure ulcer with the likelihood of further skin complications. Findings include: Resident #6: ON 4/29/24, at 9:34 AM, Resident #6 was lying on their back in their bed. They complained that they have a wound on their bottom. Resident #6 stated, they didn't have it when they got there. On 4/29/24, at 3:22 PM, Resident #6 was lying in their bed on their back. On 4/30/24, at 9:00 AM, a record review of Resident #6's electronic medical record revealed an admission on 4/05/2024 with diagnoses that included Diabetes, Anemia and Heart Failure. Resident #6 required extensive assistance with Activities of Daily Living (ADL) and had intact cognition. There were no lab results for review in the record. A review of the ADL self-care performance deficit care plan revealed . Interventions . BED MOBILITY: 2 person assist with B/L (bilateral) Assist bars for increased mobility. Date Initiated: 04/06/2024 . A review of the impaired skin integrity care plan revealed . (the resident) has Pressure Unstageable: Coccyx . has scar tissue from past Pressure ulcers on sacrum and bilateral Glutes Date Initiated: 04/17/2024 . Interventions . Air mattress to bed Date Initiated: 04/17/2024 . Assist resident with turning and repositioning as needed Date Initiated: 04/17/2024 . There was not a care plan implemented on admission for Resident #6's pressure ulcer history and Braden scale that determined the resident to be At Risk for impaired skin integrity upon admission. A review of the BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK . admitted : 4/6/2024 revealed Score: 17 . AT RISK . A review of the progress notes revealed: 4/6/2024 . Nursing Evaluation Summary . No skin issues or wounds . 4/16/2024 15:19 (3:19 PM) Alert Note . A new skin problem was observed. (resident) has reddened area on admission, now open. New orders placed, wound NP will assess in the am. A review of the WOUND EVALUATION . Evaluated on [DATE] . Pressure - Unstageable (Slough and/or eschar) . coccyx . Acquired: In-House Acquired . Length 5.42 cm (centimeters) Width 3.02 cm . WOUND EVALUATION . May 1 . Length 5.68 cm Width 1.88 cm . Progress Improving . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/01/24, at 8:40 AM, the Director of Nursing (DON) and UM F were interviewed regarding Resident #6's In-House Acquired Unstageable Pressure ulcer. UM F offered that they thought is was an unavoidable pressure ulcer. UM F was asked to provide a record review of any other documents regarding aiding in the prevention of the Pressure Ulcer from admission until development and UM F offered they would look into it. A review of the facility provided Pressure Ulcer/Skin Breakdown - Clinical Protocol Revised: 1/1/2022 revealed . An admission evaluation helps identify residents at risk of developing a pressure ulcer/pressure injury (PU/PI), and residents with existing PU/PI's. Because a resident at risk can develop a PU/PI within hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent PU/PI. The admission evaluations helps define those initial care approaches . Complete the Norton Plus or standardized skin risk assessment upon admission . Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview, and record review the facility failed to abide by one resident's (Resident #3) assessed level of assistance during incontinence care, resulting in Resident #3 rolling off of her bed and onto the floor during care and sustaining a preventable femur fracture that required surgical intervention. This citation was cited at Past Non-Compliance with a Compliance Date of 11/06/2023. Findings Include: Resident #3: On 4/29/2024 at 12:15 PM, an interview was conducted with Resident #3 regarding her stay at the facility. She reported while she recently has shown improvements, she had a fall in October 2023 when she rolled out of bed during a brief change and broke her leg. Resident #3 reported she required surgical intervention and screws in her leg from the ordeal. Resident #3 stated she is a two-person assist and the Certified Nursing Assistant (CNA) placed her on the bedpan and attempted to change out her brief alone. Resident #3 alerted the CNA she needed to use the bedpan and the CNA went to obtain one and then placed it underneath her. The CNA removed the bedpan and placed the brief underneath the resident; as she completed that task, Resident #3 heard the brief tear. The resident started she was already close to the edge of the bed, but the CNA was not paying much attention to her positioning in the bed and was on the left side of the bed (the resident fell to the right side of the bed). As the CNA was changing out the briefs, the resident was rolled toward the right and she continued to roll and hit the floor. On 4/29/2024 at approximately 1:30 PM, a review was completed of Resident #3's medical records, and it indicated she was admitted to the facility on [DATE] with diagnoses that included, femur fracture, spinal stenosis, syncope and collapse and hyperlipidemia. Resident #3 is cognitively intact and able to make her needs known. Further review yielded the following: Care Plan: .Bed Mobility: a 2 person assist with b/l (bilateral) enabler bar to increase mobility .Toileting: 2 Person assist . initiated on 8/23/2023. Kardex: .Bed mobility: 2 person assist with b/l enabler bars to increase mobility .toileting: 2 person assist . Incident and Accident Report: (continued on next page)

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Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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F 0689 Level of Harm - Actual harm Residents Affected - Few	I asked for the bed pan. She got the bed pan under me. I used the bathroom. She took the bed pan off. the brief was wet and I head I tear. So, I tried to help and lift up the best I could to give her some help to put the new brief on and the other off. I wind up falling over the bed. The last tug I was real close to the end of the bed and I feel off the bed .Nurse assessed resident, no new skin issues observed at this time .Resident hoyered back to bed .Resident continues to complain of bilateral knee pain. Resident cried out in pain when moving each knee . Progress Notes: Nurse Notes: 10/26/2023 at 16:25: Taken from nurse notes: Resident stated to nurse . I asked for the bed pan. She got the bed pan under me. I used the bathroom. She took the bed pan off. The brief was wet and I heard it tear. So, I tried to help and lift up the best I could to give her some help to put the new brief on and the other off. I wind up falling over the bed. The last tug I didn't realize I was close to the end of the bed and I fell off the bed. 10/26/2023 at 17:07: Resident was sent to hospital following a fall out of bed. She c/o (complaints of) pain 10/10 in her r (right)/leg . Hospital Discharge Summary: Admission diagnosis: fall from bed, other closed fracture of distal end of right femur .Right knee showed displaced, comminuted fracture of the distal femoral metadiaphysis .CT knee right showed significant comminuted fracture of distal femoral metadiaphysis fracture extends to femoral trochlea articular surface . Patient went over reduction internal fixation of the right femur with orthopedic surgery .wound vac in place . Practitioner Notes: 10/26/2023 00:00: New fall from bed while rolling during bed change. Complaints of knee and hip pain. Requests send out. 11/6/2023 00:00: [AGE] year-old female patient seen today to reestablish care. Patient had a fall and incurred a femur fracture. She underwent surgical repair. She was then stabilized and sent back to this facility for further medical care and rehab . On 4/30/2024 at 5:37 PM, an interview was conducted with CNA X regarding Resident #3's fall from the bed as she was providing incontinence care. CNA 'X shared Resident #3 requested to be placed on the bedpan and when removing the bedpan some of the urine splashed onto Resident #3's brief causing her to have to change the brief out. CNA X stated she was on the left side of Resident #3 and lightly pushed her to the right side as Resident #3 held onto her right enabler bar. CNA X stated she attempted to prevent the resident from falling but was unsuccessful as the resident rolled off the bed toward the right side and landed face down on the floor. CNA X reported she rolled Resident #3 away from her as that was how she was trained in their CNA certification class. She admitted she knew Resident #3 was a 2-person assist, but still completed incontinence care alone as other staff were busy, but she knows now she should have waited for someone to assist her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/30/2024 at 8:45 PM, an interview was held with Nurse P regarding Resident #3's fall with fracture. Nurse P reported upon arrival to the resident's room she was observed undressed and face down on the right side of the bed. Nurse P and Nurse W assessed the resident, and she had pain in her side but was agreeable to be being turned over. They moved everything out the way to provide ample space to assess Resident #3 and place her back in bed. Upon turning her over they assessed, covered her, and placed he back in bed. Resident #3 did not have any obvious injuries and she assessed the resident within her limitations as she does not move that much. Nurse P questioned CNA X who explained Resident #3 requested the bedpan which the aide provided and as she either removed the bedpan or placed the brief is when the resident fell . Nurse P stated Resident #3 can use the bilateral assist bars to pull up some to assist during care. Nurse P reported Resident #3 is care planned for 2 persons assist but this was not followed in this instance. On 5/1/2024 at 11:20 AM, an interview was conducted with Nurse W regarding Resident #3's fall with fracture. Nurse W reported the CNA rolled Resident #3 and she went over the bed and onto the ground. Upon arrival to the room Resident #3 was face down on the floor. Nurse W reported Resident #3 is a 2-person /max assist and she asked CNA 'X if she checked the residents Kardex prior to providing care and the CNA knew that she did not utilize the appropriate assistance. The facility completed a Past Non-Compliance (PNC) related to Resident #3's fall with femur fracture due to improper assist level. Facility Past Non-Compliance (PNC): One CNA was performing bed mobility with resident when the care plan stated 2 staff for bed mobility . Facility sweep was completed on like residents requiring 2 staff for bed mobility. We identified 19 like residents requiring 2 staff assistance for bed mobility CNA staff completed education to include competency checks on residents that required 2 person bed mobility. Witness Statements: Nurse W on 10/26/2024: She was turned over on her side, she was holding herself up with the railing. I told her we needed to change the brief, (it got wet removing bed pan. I took the old one out. When I was placing the new one on. Resident pulled herself up and over to help. Resident flipped over railing. I tired to grab her. Unsuccessful trying. I yelled for the nurse to come immediately as I stayed with her. Resident #3: I asked for the bed pan. She got the bed pan under me. I used the bathroom. She took the bed pan off. the brief was wet and I head I tear. So, I tried to help and lift up best I could to give her some help to put the new brief on and the other off. I wind up falling over the bed. The last tug I was real close to the end of the bed and I feel off the bed. CNA X Training: - Turning and repositioning competency signed on 10/18/2023. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- CNA X was reeducated on 11/6/2024 You much read each residents Kardex before providing care and if it says 2 person than 2 person much be present and hands on to assist. Never roll a resident away from you when providing care. On 5/1/2024 at 2:50 PM, a interview was conducted with the DON (Director of Nursing) regarding the facility PNC (Past Non-compliance). The DON reported since Resident #3's fall there have been no other falls in the facility due to improper transfer. Upon CNA X being interviewed she was truthful that she used the incorrect assistance and and knew the resident was a two person assist. The DON stated she a new CNA but was training on turning on repositioning on 10/18/2023. Since the incident they have completed monitoring of residents who require two person assist. Their audits went into 2024 to ensure substantial compliance but their PNC date is 11/6/2023. Review was completed of training document entitled Turning and Repositioning, It stated, .Always check how many staff are required to turn and reposition .If the resident is 2 person assist for tuning and repositioning bot staff should be present .Ensure the person is in the center of the bed . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which include facility sweep of like residents who required two person assist for bed mobility, audits to ensure compliance but management staff, education and competency for CNA regarding following correct level of care and followed in QAPI. for The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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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** 38471 Based on observation, interview, and record review the facility failed to timely assess, investigate, implement appropriate interventions, and notify practitioners and the dietitian of significant weight loss for one resident (Resident #13) of one resident reviewed for excessive weight loss, resulting in a significant weight loss of 32. 3 pounds (12.52%) with delayed facility assessment and intervention for Resident #13. Findings Include: Resident #13: During initial tour, Resident #13 was observed in the dining room perusing a magazine. The resident was asked about her weight loss in January 2024, and stated she had to lose some weight as she is a basketball player. On 4/30/2024 at 9:00 AM, a review was completed of Resident #13's medical records and it revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included, Diabetes, Atrial Fibrillation, Schizophrenia, Anxiety, Dementia, Eating Disorder, Hemiplegia and Hemiparesis. Further review yielded the following: Care Plan: .Notify dietitian and Physician/PA (Physician Assistant)/NP (Nurse Practitioner) of significant weight changes . Weight Summary: 10/4/2023- 259.4 11/9/2023- 258.2 12/5/2023-257.9 1/9/2024- 225.6 1/22/2024- 226.6 It can be noted on 12/05/2023, the resident weighed 257.9 lbs. On 01/09/2024, the resident weighed 225.6 pounds which is a -12.52 % loss over the one month. Progress Notes: Practitioner Note: 1/10/2024: No mention 32.3-pound weight loss in one month (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/17/2024: No mention 32.3-pound weight loss in one month 1/24/2024: No mention 32.3-pound weight loss in one month 1/25/2024: No mention 32.3-pound weight loss in one month Nursing Notes: There were no nursing progress notes regarding Resident #13's weight loss or their notification to Registered Dietitian or the facility practitioner's. Dietary Notes: 1/11/2024 at 10:03: Requesting re-weight due to large discrepancy . 1/22/2024 at 17:13: Reweigh requested to validate the weight loss seen .adding resident to nutrition SOC to monitor for 2 weeks for further weight loss . On 4/30/2024 at 11:16 AM, an interview was conducted with Registered Dietitian L regarding Resident #13's significant weight loss in January 2024. Dietitian L explained CNA (Certified Nursing Assistant) complete the weights at the facility and if a resident triggers for weight loss, it will alert in their system, and she would request a reweight to validate the weight loss/gain. Dietitian L explained if she is not in the facility an email will be sent to the Administrator, DON (Director of Nursing) and Unit Manager to request the reweight. Dietitian L reviewed Resident #13's weights and stated she triggered on 1/9/2024 and the reweight was requested two days later (1/11/2024) by their Regional Dietitian. The reweight was not completed until 1/22/2024 (11 days after the dietitian request and 13 days after the initial weight was recorded). Dietitian L stated this weight loss was considered significant for Resident #13. Review was completed of the facility policy entitled, Weight Monitoring, revised 10/26/2023. The policy stated, .Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss may indicate a nutritional problem .A weight monitoring schedule will be developed upon admission for all residents: a. Weight should be recorded at the time obtained; b. Newly admitted residents- monitor weights weekly for 4 weeks; c. Resident with weight loss- monitor weight weekly; d. If clinically indicated- monitor weights daily .Weight analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in weight in 1 month (30 days); b. 7.5% change in weight in 3 months (90 days); c. 10% change in weight in 6 months (180 days) .The physician should be informed of a significant change in weight .The Registered Dietitian should be consulted to assist with interventions; actions are recorded in nutrition progress notes .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 39059 Based on observations, interview and record review, the facility failed to assess and monitor Percutaneous Inserted Central Catheter (PICC/a central line placed into a vein in the upper arm guided into a large vein above the heart) per standards of practice and failed to notify the physician of an inward migration of the PICC for two residents (R#39, 200), resulting in a complication of a 3.5 centimeter (CM) inward migration going unassessed, missed dressing changes, flushes, end cap changes with the likelihood of further complications such as further inward or outward migration, swelling, site infection going unassessed and/or unnoticed. Findings include: Resident #39: On 4/29/24, at 11:45 AM, Resident #39 was resting in their room. They had a PICC line to their left upper arm. The dressing was dated 4-27-24 and was intact. On 4/29/24, at 3:30 PM, a record review of Resident 39's electronic medical record revealed an admission on 4/9/24 with diagnoses that included Osteomyelitis, Diabetes and mood disorder. Resident #39 had intact cognition and required assistance with Activities of Daily Living. A review of the physician progress notes revealed 4/11/2024 . History and Physical . Patient was started on broad-spectrum IV antibiotics . Patient was treated and stabilized and transferred to this facility for continued medical care . Peperacillin Sod-Tazobactam So Solution Reconstituted 3-0.375 GM: Use 3.75 GM intravenously every 8 hours for infection until 05/14/2024 . A review of the progress notes revealed 4/13/2024 . continues on IV antibiotics . 4/18/2024 . continues on IV abx . 4/20/2024 . continues on IV abx . The progress notes did not have PICC line site/care documented until 4/22/2024 which revealed 4/22/2024 16:33 (4:33 PM) Nurses' Notes . Measurements taken surrounding PICC 27 cm circumference and 13.3 cm length. This writer will find a transparent dressing for night nurse to place on resident . A review of the Physician orders revealed Transparent dressing change every 7 days and as needed. Document in progress notes any concerns such as changes to sit, s/s infection, or complications Start Date 4/22/2024 . Normal Saline Flush Solution 0.9 % . Use 10 ml (milliliters) intravenously . Start Date 4/22/2024 . Observe for patient condition, s/s of infiltration or extravasation. Document any abnormal findings and follow-up with provider as indicated. Every shift for single lumen . Start Date 4/22/2024 . Change needleless connector on admission, every 7 days, after blood draws, and prn as clinically indicated . Start Date 4/22/2024 . Change sterile end cap on intermittent administration set after each use . Start Date 4/22/2024 . Piperacillin Sod-Tazobactam So Solution Reconstituted 3-0.375 GM Use 3.375 gram intravenously . Start Date 4/11/2024 End Date 5/14/2024 . The resident admitted and began the IV antibiotics (abx) on 4/9/24 and had not have orders for the PICC line until 4/22/24 which was 13 days later. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the 4/1/2024 - 4/30/2024 TREATMENT ADMINISTRATION RECORD revealed Transparent dressing change every 7 days and as needed. Document in progress notes any concerns such as changes to site, s/s infection, or complications as needed Supplementary documentation includes: Arm circumference in cm. (ACC) Catheter Length in cm. (CL) -Start Date- 04/22/2024 . Mon 22 ACC 28 CL 9.5 The catheter length in cm (CL) documented on the TAR revealed a 3.5 cm inward migration of the catheter. The doctor was not notified. On 5/01/24, at 8:45 AM, The Director of Nursing (DON) and Unit Manager F was interviewed regarding Resident #39's PICC care. UM F offered that the orders weren't placed until 4/22. UM F and DON was asked where the PICC assessments were documented prior to 4/22 and UM F stated, there weren't any. According to [NAME] and [NAME] Clinical Nursing Skills and Techniques 10th edition, Intravenous and vascular access . dressing: change at least every 5-7 days . Inspect catheter, insertion site and surrounding skin . For PICC . measure upper-arm circumference 10 cm above antecubital fossa . Insertion sites require regular inspection for early detection of signs and symptoms of IV-related complications . Measurement of external catheter length provides comparison to determine dislodgement, arm measurement with a 3-cm increase can indicated thrombosis (blood clot) . Resident #200: On 4/29/2024 at 2:53 PM, Resident #200 was observed sitting in his wheelchair visiting with his wife. His wife reported he recently admitted to the facility and his PICC is not new. This writer observed the PICC line dressing on his upper right arm that was not occlusive, was not dated nor initialed by the nurse. It is unknown when the last time his PICC dressing was changed. On 4/20/2024 at approximately 10:30 AM, a review was completed of Resident #200's medical records and it revealed he admitted to the facility on [DATE] with diagnoses that included Atrial Fibrillation, Subacute Osteomyelitis, Dementia and Sepsis. Further review of Resident #200's chart yielded the following: Care Plan: .Resident has an IV (Specify: Central line, Peripherally Inserted Central Catheter (PICC), Midline , Peripheral line) related to .IV catheter care, maintenance and dressing changes per orders .initiated on 4/20/2024. Progress Notes: 4/20/2024 at 11:13: (Resident #200) arrived .admission diagnosis of sepsis he has a PICC in upper right arm (Resident #200) will be on IV abx (antibiotic) Vancomycin Q12h (every 12 hours) for 61 doses last vanco trough was on 4/18/24 results 23.3 . April 2024 MAR (Medication Administration Record) and TAR (Treatment Administration Record): Resident #200 has no orders in place for his PICC line care until four days after admission: - Change needleless connector on admission every 7 days, after blood draws, and prn (as needed) as clinically indicated. Start date 4/25/2024. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Transparent dressing change every 7 days and as needed. Document in progress notes any concerns such as change to site, s/s (signs and symptoms) infection, or complications. Every day shift every 7 day (s). Supplementary documentation includes: Arm circumference in cm (centimeters), (ACC) Catheter Length in cm. (CL). Start date: 4/25/2024 at 0700. -There were no measurements documented under this order - Change sterile end cap on intermittent administration set after each use every shift schedule and cap change to correspond with each use. Label with date/time/initials. Start date: 4/24/2024. Resident #200's PICC line dressing was documented as completed on 5/1/2024 (during recertification and 11 days after admission). There was no other documentation located that indicated facility staff completed the appropriate PICC line measurements for Resident #200. On 5/1/2024 at 11:47 AM, an interview was conducted with Nurse D regarding Resident #200's PICC line measurement, dressing changes and orders. Nurse D explained that upon admission the skin assessment portion of the admission assessment would have alerted the nurse to input the PICC line orders into the system. In the MAR/TAR under PICC line dressing there is a designated spot to input the measurements (arm circumference and catheter length). This writer and Nurse D reviewed Resident #200's MAR/TAR and there were no measurements found and the first PICC line treatment order was on 4/24/2024.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview, and record review, the facility failed to ensure that one resident (Resident #100) was free of an unnecessary dose of Coumadin anti-coagulation with elevated laboratory Protime (PT) and International Normalized Ratio (INR) levels, resulting in the likelihood for excessive bleeding and hospitalization . Findings include: Record review of the facility 'Medication Administration' policy, dated 1/17/2023, revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so on this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The facility medication administration policy had no instructions for nurses to monitor therapeutic laboratory levels prior to administration of high-risk medications or to address Black Box Warnings of medications. Record review of the 'Nursing 2017 Drug Handbook' page 1512-1515, revealed Coumadin anticoagulant with oral administration draw blood to establish baseline coagulation parameters before therapy. Protime (PT) and International Normalization Ratio (INR) determinations are essential for proper control. Recommended INR range is usually 2 to 3 for most patients. Nursing considerations: Black Box Warning- Coumadin can cause major or fatal bleeding . Regularly monitor International Normalization Ratio (INR) in all patients. Record review of the 'Nursing 2017 Drug Handbook' page vii How to use nursing drug handbook identified that a Black Box warning: represents a specific warning issued by the FDA (Food & Drug Administration). Resident #100: Record review of Resident #100's admission Minimum Data Set, dated dated [DATE], revealed an elderly resident with medical diagnosis of: Atrial fibrillation, heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, benign prostatic hyperplasia, diabetes, thyroid disorder, arthritis, and malnutrition. Section N: High Risk Medications: Anticoagulant, Antibiotic, Diuretic, Opioid, Antiplatelet, Hypoglycemic (Insulin). Record review of Resident #100's April 2024 Medication Administration Record (MAR) noted: PT and INR one time a day every Monday, Wednesday, Friday related to Chronic Diastolic (Congestive) Heart Failure start date 4/22/2024 scheduled at 5:00 AM. Record review of the PT/INR order noted blank MAR days on 4/22/2024, 4/26/2024, and 4/29/2024. Record review of Resident #100's Progress notes, dated 4/22/2024 through 4/30/2024, revealed that on there was documentation of the nurses monitoring the PT/INR laboratory results. Record review of Resident #100's Nurse Practitioner progress note dated 4/24/2024 at 00:00 telehealth visit/note noted INR 3.66 Coumadin 2mg given. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/24 at 12:22 PM, Nurse Practitioner (NP) J reviewed the PT/INR lab results of elevated values and stated per nursing policy the facility checks PT/INR three days a week. The NP had a discussion with her supervisor and were to hold the Coumadin from 4/27/24 through 4/29/2024 when the next lab results of the next draw come back. We are giving the medication Coumadin for atrial fibrillation for clot prevention. Therapeutic INR level goal was to be between 2.0- 3.0. In an interview and record review on 05/01/24 at 01:05 PM with Licensed Practical Nurse (LPN) LPN/Unit Manger F of Resident #100's Coumadin anti-coagulant (Blood thinner) 2.5mg oral every day at 9:00 PM, LPN/Unit Manager F stated that the PT/INR is used for their blood bleeding time, we don't want them to thin, we would hold the Coumadin if the level is too high. Record review of Resident #100's April 2024 Medication Administration Record (MAR) revealed that the PT/INR was not being documented on the MAR record consistently. The surveyor stated that the Coumadin is a Black box high risk medication. The LPN/Unit Manager F stated that she would not give the Coumadin unless she knew what was that PT/INR levels. That it was a nursing standard of practice. Record review of the April 2024 Medication Administration Record revealed that on 4/26/2024 at 9:00 PM the medication dose was given. Record review of Resident #100's laboratory blood work results on 4/26/2024 at 9:04 AM revealed PT/INR 35.6/3.58 (high levels). on 4/27/2024 the provider was notified, and the medication was held. Coumadin is an anti-coagulant/blood thinner; it can cause bleeding if levels are elevated. In an interview and record review on 05/01/24 at 01:44 PM, the Director of Nursing (DON) reviewed records of Resident #100's PT/INR (Protime (PT) and International Normalization Ratio (INR) on 4/26/2024 at 9:04 AM- levels 35.6/3.58- and stated the levels are too high and the medication should not be given. Record review of the medication administration record identified that the medication was given on 4/26/2024 in the evening. In an interview on 05/01/24 at 03:08 PM, the Director of Nursing (DON) revealed that the facility did not have a Coumadin or PT/INR nursing policies per corporate, or a lab report policy.

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Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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F 0758 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 22927 Based on observation, interview and record review, the facility failed to ensure that informed consents were obtained for non-psychotropic medications used to treat mood and behavior disorders and/or hypnotic medications for seven residents (#11, #29, #31, #37, #40, #41, #100), resulting in residents receiving medications with the lack of consents for the use and potential for unnecessary and undesired medication use. Findings include: Record review of the facility 'Medication- Psychotropic policy dated 10/30/2023 revealed residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). A psychotropic drug is any drug that affects the brain activities associated with mental processes and behavior. Record review of the facility 'Use of Psychotropic Drugs and Gradual Dose Reductions' policy dated 10/30/2023 revealed residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. (#19.) Other medications which may affect brain activity such as central nervous system agents, mood stabilizers, anticonvulsant's, muscle relaxants, anticholinergic medications, antihistamines, NMDA receptor modulators, and over the counter natural or herbal products must also only be given with a documented clinical indication consistent with accepted clinical standards of practice. Resident #31: Record review of Resident #31's physician orders In an interview and record review on 04/30/24 at 11:09 AM with the social service designee H of Resident #31's physician orders and signed medication consent was for Paliperidone ER Oral Tablet Extended Release 24 Hour 3 MG (Paliperidone). there were no consents found for Lamictal 100mg oral tablets by mouth two times a day for related bipolar disorder or Depakote sprinkles 125mg give 2 capsules by mouth two times a day for depression/bipolar. The Social work designee stated that the Lamcital and Depakote were not psychotropic's and needed no consent. the state surveyor inquired about the use of the medications as mood stabilizers related to the bipolar diagnosis and behaviors. (continued on next page)

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F 0758 Level of Harm - Potential for minimal harm Residents Affected - Some	In an interview and record review on 04/30/24 at 11:29 AM with the social services designee H revealed that she reached out to her corporate social services consultant and the facility are to have consent if using as mood stabilizer, such as for Resident #31's bipolar moods. Social services designee H stated that she did not know that and reached put to the corporate SW and will be doing an audit of who we are using the mood stabilizing meds and get consents. Record review of policy of the psychotropic medication policy was done. in an interview and record review on 04/30/2024 at 11:49AM with Social Services Designee H brought the surveyor an audit of 7 residents that needed consents for mood stabilizers, and/or hypnotics. Record review of 'Consent to Use Psychoactive Medication Therapy' forms all dated 4/30/2024: Resident #11: Depakote for mood disorder with psychotic features. Reduce adverse behaviors. Mood stabilizer. Resident #29: Topamax for mood disorder with psychotic features. Reduce adverse behaviors. Mood stabilizer. Resident #200: Ramelteon for sleep disorder. Sedative/Hypnotic. Resident #31: Lamictal for bipolar disorder to reduce adverse behaviors. Mood stabilizer. Depakote for bipolar to reduce adverse behaviors. Mood stabilizer. Resident #37: Divalproex for dementia without behavioral disturbance to reduce adverse behaviors. Mood stabilizer. Resident #41: Depakote for dementia with behavioral features, hallucinations. To reduce adverse behaviors. Mood stabilizer. Resident #40: Depakote for dementia with behavioral features, hallucinations. To reduce adverse behaviors. Mood stabilizer.

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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. 22927 Based on observation, interview and record review, the facility failed to ensure that the medication error rate was less than 5% when 7 late administrations of medications were observed and 2 medication errors from a total of 30 opportunities for two residents (Resident #100, Resident #200) of 5 residents reviewed. This deficient practice resulted in a medication error rate of 30% and the likelihood for the risk of adverse medication effects and decreased medication efficacy. Findings include: Record review of the facility 'Medication Administration' policy dated 1/17/2023 revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so on this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. (#11.) Compare medication source with the MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, and time of administration. (a.) Refer to drug reference materials if unfamiliar with the medication, including it mechanism of action or common side effects. (b.) Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Observation and interview on 05/01/24 at 10:04 AM with Licensed Practical Nurse (LPN) D of Resident #200 was taken to his room from dining room by Certified Nurse Assistant A. Observation of Resident #200 was seated up in wheelchair. The call light was left on the bed out of reach of Resident #200. The state surveyor asked LPN D why the call light was left on the left side of the bed when the resident was seated on the right side of the bed out of reach. LPN D stated that it should not be on that side of the bed when he is over here on the window side of the bed. Observation and interview on 05/01/24 at 10:08 AM with LPN D during the medication administration task revealed that Resident #200's right upper arm PICC line (Peripherally Inserted Central Catheter) dressing was dated 5/1/2024 at 5:45 AM by initials SC. LPN D Removed the old bag of Vancomycin 750 mg/250 ml bag and proceeded to hang the new bag of Vancomycin 500 mg/100 ml and new IV line set bleed through. That bag of Vancomycin 500 mg/100 ml was wasted by LPN D due to it was reconstituted earlier in the morning. LPN D stated that she had called pharmacy the day prior to get a new dose of Vancomycin because the Vancomycin lab values were elevated and the dose needed adjusting, but that the night shift hung the stronger previous dose. Observation on 5/1/2024 following the Vancomycin antibiotic intravenous administration of the East medication storage room revealed a clear plastic bag from the pharmacy with four doses of Vancomycin 500 mg/100 ml bags laying on the counter labeled for Resident #200. The Pharmacy clear plastic bag identified that there were four doses sent and that none of the doses were given as ordered. Observation at 10:33 AM of Resident #200's Vancomycin 500 mg/100 ml intravenously was administered at this time. Observation on 5/1/2024 at 10:35 AM of the East nursing station revealed that both Licensed Practical Nurses D and E were still passing the residents morning medications. Record review of facility provided 'Medication Admin Audit Report' dated 5/1/2024 for Resident #100 revealed that the residents received 5 prescriptions 8:00 AM medications at 9:26 AM, over the policy 60-minute requirement. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility provided 'Medication Admin Audit Report' dated 5/1/2024 for Resident #200 revealed that the resident received 7 prescriptions 8:00 AM medications after 10:30 AM, over the policy 60-minute requirement.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to prevent significant medication errors for two residents (Residents #100, Resident #200) of five residents reviewed for medication errors, when a nurse administered an anticoagulant (Blood thinner) with an elevated International Normalization Ratio (INR) to Resident #100, and another nurse administered the wrong strength of Vancomycin antibiotic medication with an elevated Vancomycin laboratory level, resulting in the likelihood for prolonged illness and hospitalization . Findings include: Record review of the facility 'Laboratory and Diagnostic Guidelines' policy dated 10/26/2023 revealed the guideline is set up to track the timely completion, reporting and monitoring of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status and/or therapeutic medication levels. Record review of the facility 'Medication Administration' policy dated 1/17/2023 revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so on this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. (#11.) Compare medication source with the MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route, and time of administration. (a.) Refer to drug reference materials if unfamiliar with the medication, including it mechanism of action or common side effects. Resident #100: Record review of Resident #100's Minimum data Set (MDS) dated [DATE] revealed an elderly male with active medical diagnosis of: Atrial fibrillation, heart failure, hypertension, peripheral vascular disease, gastroesophageal reflux disease, benign prostatic hyperplasia, diabetes, thyroid disorder, arthritis, and malnutrition. Section N: Medications- Anticoagulant, antibiotic, diuretic, opioid, antiplatelet and hypoglycemic medications were identified. Record review of Resident #100's Medication Administration Record (MAR) for the month of April 2024, revealed Coumadin (anticoagulant) 2.5 mg give one tablet by mouth one time a day related to chronic diastolic (congestive) heart failure at 9:00 PM. The medication was started on 4/20/2024 and held on 4/25/2024, given on 4/26/2024, and held on 4/27/24 and 4/28/24. The April MAR noted: PT (Protime) and INR (International Normalization Ratio) one time a day every Monday, Wednesday, Friday related to chronic diastolic (congestive) heart failure at 5:00 AM. The order was started on 4/22/2024 with the administration initial square was blank that day and again on 4/26/24 and 4/29/24. Record review of Resident #100's laboratory PT/INR results dated 4/26/2024 at 9:04 AM revealed an INR (International Normalization Ratio) result of 3.58 (elevated level). Record review of Resident #100's Medication Administration Record (MAR) for the month of April noted that on 4/26/2024 at 9:00 PM Coumadin 2.5mg was given by nurse with the elevated INR levels increasing the likelihood for bleeding or hospitalization . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and records review on 05/01/24 at 12:22 PM with the Nurse Practitioner J revealed would like to keep the Resident #100's (International Normalization Ratio) INR at 2.5. Record reviewed of Resident #100's PT/INR lab results of elevated values on 4/26/2024. THE NP J stated that per nursing policy the facility checks PT/INR three days a week and had a discussion with medical supervisor and to hold the Coumadin from 4/27/24 through 4/29/2024 when the next lab results of the next draw come back. Resident #100 was receiving the medication Coumadin for atrial fibrillation/heart failure for clot prevention. In an interview and record review on 05/01/24 at 01:05 PM with Licensed Practical Nurse/Unit Manager F revealed that Resident #100 was receiving Coumadin (anticoagulant) 2.5mg every day at 9:00 PM. LPN/UM F stated that the PT/INR (Protime/International Normalization Ratio) blood laboratory was used for blood bleed time because we don't want the blood to thin. LPN/UM F revealed that the facility nurse would hold the Coumadin if the level were too high. Record review with LPN/UM F of Resident #100's Medication Administration Record (MAR)/Treatment Administration Record (TAR) April 2024 revealed that the PT/INR was not being documented on the MAR/TAR record consistently. The surveyor stated that the Coumadin is a Black box high risk medication. The LPN/UM F stated that she would not give the Coumadin unless she knew what was that PT/INR levels were. Record review of the April 2024 Medication Administration Record (MAR) revealed that on 4/26/2024 at 9:00 PM the Coumadin 2.5mg medication dose was given, when the lab on 4/26/2024 at 9:04 AM PT/INR 35.6/3.58, that was noted as high. on 4/27/2024 the medical provider was notified, and the medication was held. Coumadin is an anti-coagulant/blood thinner; it can cause bleeding if levels are elevated. Resident #200: Record review of the facility pharmacy services Vancomycin Therapy' policy dated 3/2022 revealed the purpose was to provide guidance to a licensed nurse on the administration of intravenous Vancomycin. Vancomycin therapy is used to treat suspected susceptible organisms based on lab cultures and sensitivities. Vancomycin is used to treat many gran-positive bacteria but is generally saved for bacteria that is resistant to other treatments such as MRSA (Methicillin-sensitive Staphylococcus aureus and various susceptible strains of Methicillin Staphylococcus aureus . The facility will be responsible to provide clinical information related to the patient's therapy if the information to (pharmacy services). Patient diagnosis, height, weight, age, and serum creatinine allow the pharmacist to estimate the proper IV Vancomycin dose. On-going monitoring of serum creatinine levels, BUN and Vancomycin trough levels minimize adverse reactions associated with the therapy. Facility personnel shall assist the pharmacist by providing serum creatinine levels, BUN and any reported Vancomycin trough levels when ordering this medication. Record review of Resident #200's blood laboratory results of Vancomycin level trough on 4/29/2024 at 9:28 AM revealed elevated level of 20.9. The lab indicated H for high on the form. Record review of Resident #200's Medication Administration Record (MAR)/Treatment Administration Record (TAR) April 2024 revealed that on 4/23/2024 at 8:00 PM Vancomycin 750 mg intravenously (IV) two times a day related to subacute osteomyelitis of left ankle/foot was ordered. On 4/30/24 at 11:22 AM the order was discontinued. On 4/30/2024 at 8:00 PM new order for Resident #200's Vancomycin 500 mg intravenously (IV) two times a day related to subacute osteomyelitis of left ankle/foot was ordered. The new order was signed out as given on 4/30/24 at 8:00 PM by a facility newly-hired orientee. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/01/24 at 10:08 AM with LPN D during the medication administration task revealed that Resident #200's right upper arm PICC line (Peripherally Inserted Central Catheter) dressing was dated 5/1/2024 at 5:45 AM by initials SC. LPN D Removed the old bag of Vancomycin 750mg/250ml bag and proceeded to hang the new bag of Vancomycin 500mg/100ml and new IV line set bleed through. That bag of Vancomycin 500mg/100ml was wasted by LPN D due to it was reconstituted earlier in the morning. LPN D stated that she had called pharmacy the day prior to get a new dose of Vancomycin because the Vancomycin lab values were elevated and the dose needed adjusting, but that the night shift hung the stronger previous dose. Observation on 5/1/2024 following the Vancomycin antibiotic intravenous administration of the East medication storage room revealed a clear plastic bag from the pharmacy with four doses of Vancomycin 500mg/100ml bags laying on the counter labeled for Resident #200. The Pharmacy clear plastic bag identified that there were four doses sent and that none of the doses were given as ordered. Observation at 10:33 AM of Resident #200's Vancomycin 500mg/100ml intravenously was administered at this time. In an interview and records review on 05/01/24 at 12:46 PM in regard to Resident @200's Vancomycin antibiotic therapy with Licensed practical Nurse/Unit manager (LPN/UN) F revealed that Resident #200 was on Vancomycin 750/250ml twice daily, that order changed on 4/30/24 at 11:22 AM by the day shift nurse LPN D, Because the trough was elevated 20.9 that is elevated therapy value. Record review of Resident #200's April Medication Administration Record (MAR) revealed that Registered Nurse (RN) P and her orientee hung the Vancomycin 750mg/250ml bag. LPN/UM F stated that is a huge problem. The state surveyor identified that the Vancomycin trough level lab value on 4/29/2024 was available at 9:28 AM. Record review of Resident #200's April MAR revealed that the 4/29/2024 8:00 PM dose of Vancomycin 750mg was administered with no nurse calling or identifying the Vancomycin trough level. Licensed Practical Nurse (LPN) D worked on 4/30/2024 day shift and looked up the Vancomycin trough lab values and change the dose via pharmacy dosing. LPN/UM F stated that the 4/29/2024 8:00 PM dose should not have been given. On 4/30/2024 at 11:22 AM the Vancomycin dose changed to 500mg/100ml intravenously twice daily, but that the night nurse RN P and orientee administered 750mg/250ml bag and it should have been the 500mg/100ml.

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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. 22927 Based on observation, interview and record review, the facility failed to follow policies and procedures for medication labeling and medication storage in 2 of 2 medication carts involving 14 residents (#3, #4, #6, #9, #13, #14, #22, #24, #32, #33, #39, #40, #44) medications and 1 of 1 medication rooms reviewed, resulting in opened and undated multi-dose medications, and the likelihood for altered medication efficiency. Findings include: Record review of the facility 'Medication Storage' policy dated 1/30/2024 revealed it is the policy of the facility to ensure all medications housed on the premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. General guidelines: (1.a.) All drugs and biological's will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. (b.) Only authorized personnel will have access to the keys to locked compartments. (c.) During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Record review of the facility 'Medications and Biological's-Labeling of' policy dated 1/1/2022 revealed all medications and biological's 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. (#8.) Labels for multi-use vials must include: (a.) The date the vial was initially opened or accessed. (b.) All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial . (#9.) Labels for medications designed for multiple administrations (such as inhalers, eye drops), the label will identify the specific resident . FACILITY: Observation on 04/29/24 at 02:23 PM of the East Unit Medication cart to the 40's-50's hallway, the state surveyor observed the unlocked medication cart parked on the back side of the nursing station with no one in attendance, the state surveyor was able to approach the medication cart and open the drawers with punch card medications and drawers with other medications of insulin pens, inhalers and over the counter medications were present. In an interview on 4/29/2024 at 2:25 PM The state surveyor inquired of the facility staff behind the nursing desk, which nurse was responsible for the medication cart and Registered Nurse (RN) G stated that she was. RN G came around the nursing station to the medication cart and the state surveyor asked the nurse why the surveyor had a medication drawer open. Registered Nurse G stated that she was talking to an aide, and somebody asked her to go check a room down the hall. RN G stated she came back, and I went into the nursing station behind the desk to talk to the aide again. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/30/24 at 08:04 AM of the Center Hall medication cart with Licensed Practical Nurse (LPN) E was reviewed. Medications of concern: Resident #39 had Lantus 10ml bottle insulin opened and used with no open date on bottle of insulin. Resident #22 had an opened 4/20/2024 Novolog pen insulin with no use by date, which LPN E stated it should be used within 30 days of opening. Resident #6 had Lispro insulin pen with no opened date or use by date. Observation and interview on 04/30/24 at 08:31 AM of the East Hall medication cart with Licensed Practical Nurse (LPN) D was reviewed. Medications of concern: Resident #9 had insulin Lantus pen opened and used with no expiration date noted to pen. Resident #24 had insulin Lantus Pen opened and used with no expiration date noted to pen. resident #100 had both Novolog and Lantus insulins both were opened and used with no expiration dates. Resident #13 had Insulins: Humalog and Basaglar insulins both were open and not dated when opened. Resident #14 had Latanoprost eye drop and Dorzolamide/Timolol eye drops 22.3mg/6.8mg with no open date or expiration date noted to bottle or boxes. Resident #4 had Fiasp insulin with no open date or expiration date. Resident #32 had Fluticasone Propionate nasal suspension 50mcg nasal spray two sprays in each nostril one time a day for allergies. There was no open date located on the nasal mister bottle. resident #42 had Fluticasone Propionate nasal suspension 50mcg nasal spray one spray both nostrils one time a day for sinus. there were no dates noted to the bottle or box. resident #3 had albuterol sulfate HFA inhalation aerosol 108mcg 2 puffs inhale orally every 6 hours as needed. The inhaler was not dated when initiated/opened. Observation and interview on 04/30/24 at 12:56 PM of the Medication room with Licensed Practical Nurse (LPN) D of the Cubix medication dispensing machine was noted. Observation of the Medication room: Resident #33 had Duo nebulizer open foil packet 0.5mg/3mg with no date when opened. Resident #40 had Trelegy Ellipta 100-62, 5 -25mcg puff inhale orally one time a day for COPD. observation of inhaler/discus with 29 doses left, comes with 30 doses. there was no date when opened. Observation of the medication refrigerator: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Covid 0.5milliter injection Resident #100 had multi-dose Novolog insulin 10ml bottle with top off, appears used with no open date on the bottle, no open date on the dark brown pharmacy outer bottle either. Tuberculin multi-dose 1ml bottle opened with no date on bottle of when opened or when expires.

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	235175	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Frankenmuth	500 W Genesee Frankenmuth, MI 48734

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38471 Based on observation and interview the facility failed to maintain sanitary conditions in the kitchen, resulting in an increased potential for cross contamination of food and foodborne illness, potentially affecting 45 residents who consume meals from the kitchen. Findings Include: On [DATE] at 9:35 AM, a tour of the kitchen was completed in the presence of Regional Dietitian L. The following expired/outdated times were found: Dry Storage Room: - 5- Minnehaha Mills Sugar Free Raspberry Gelatin packets expired [DATE] - 6- Hard shell tacos in Ziploc bag, expired [DATE] - 5lb (pound) bag of Corn Muffin mix, expired on [DATE]. - ,d+[DATE] full- 50-pound container of rice, expired on [DATE] - ,d+[DATE] full-3-gallon container of Cheerios cereal, expired on [DATE] - ,d+[DATE] full-3-gallon container of Cornflakes, expired on [DATE] - ,d+[DATE] full- 3-gallon container of Rice Krispies, expired on [DATE] Cook Refrigerator: - 5-quart container of salad mix, use by date [DATE] Walk-in Cooler: - Gallon size bag of frozen turkey or pork with no open or use by date - Gallon size bag of frozen ground beef, expired on [DATE]. - Gallon size bag of frozen turkey, expired on [DATE]. Dietary Cook M was asked who was responsible for discarding of expired foods and she reported it was the responsibility of all kitchen staff to ensure items expired items were properly disposed of. During the tour it was requested the fans in the walker in freezer and cooler were turned tuned off to observe the cleanliness of them. The walk-in cooler fan was observed with Maintenance Director I and was found to be soiled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:46 AM, an interview was conducted with Certified Dietary Manager O regarding the items found in the kitchen. Manager O reported it is the responsibility of all kitchen staff to discard of expired food, as they are in the cooler and dry storage areas daily for meal preparation. According to the 2013 FDA Food Code section ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) .FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days . (B) . if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome and process surveillance and accurate data collection/documentation/analysis including potential infections, pneumococcal vaccination tracking, and call-in/illness tracking for contracted staff resulting in lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis, and the likelihood for spread of microorganisms and illness to all 45 facility residents. Findings include: A review of the facility provided line listing data for March 2024 revealed the line listing did not include any carry over infections from the prior month (s), the Resident room number and/or room changes, any transmission-based isolation precautions, if the infection meet criteria for treatment, diagnostic testing including results/dates, and antimicrobial medication treatment duration. The line listing included a header titled, Onset Date but did not specify if that was the date when symptoms began or when treatment was initiated. The line listing did not include any Residents with sign/symptoms of infection and/or potential infection who were not receiving antimicrobial treatment other than those with Covid-19 infection. An interview and review of facility infection control data and program was completed on 4/30/24 at 9:26 AM with Infection Control (IC) Registered Nurse (RN) V. When queried, RN V revealed they started working at the facility and in the IC nurse role in February 2024. A review of infection control data for March 2024 was completed with RN V at this time. RN V provided a line listing, a summary, and a mapping tool. The numbers of infections on the line list, mapping tool and summary did not match. When queried regarding the inconsistent numbers, RN V confirmed the number of infections did not match. The line listing included 15 Residents with Covid-19 infection. When queried regarding the facility procedure related to reporting outbreaks of communicable diseases to the health department, RN V stated they were not reporting Covid or any other communicable diseases to the Health Department. When asked who their contact was at the local Health Department, RN V revealed they did not have one and were not aware of reporting guidelines related to communicable diseases. RN V was then asked why the Monthly Summary for March 2024 specified there were eight Covid positive Residents in the facility when the provided, printed line listing included 15 Covid positive residents, RN V reviewed the line list on their computer and revealed that line listing specified 17 residents were positive for Covid 19 during March 2024. When queried how many total lines were included on their listing for March 2024, RN V stated, 38. The paper line list provided to this Surveyor included 33 total lines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN V was asked why the line list on their computer and the printed list provided did not match and stated, I don't know what I'm doing. RN V disclosed they had not yet completed their organizational training and are supposed to receive more. RN V revealed the individual who had been doing infection control at the facility had already vacated the role when they started and indicated they have been doing their best to figure everything out. A diagnostic report for Resident #26 completed in March 2024 indicating a Urine Swab had been completed with the pathogens Providencia Stuartii (bacteria- opportunistic pathogen frequently identified in long term catheter use with escalating antibiotic resistance) and Escherichia coli (E-Coli bacteria- most common cause of Urinary Tract Infections [UTI]) was included in the IC binder. Resident #26 was not included on the line listing for March 2024. When queried why Resident #26 was not included on the line list, RN V replied they were not sure. When asked the reason the urine dip was completed and if Resident #26 was having signs/symptoms of a UTI, RN V revealed they were unable to answer without completing a review of the Resident's Electronic Medical Record (EMR). When queried what criteria they utilize, RN V replied, McGeer. RN V was asked where they document if the infection meet criteria on the line listing and indicated it is completed in the electronic IC program. When queried how they are tracking and monitoring antimicrobial stewardship when they are unable to quickly view and access if criteria was meet, RN V validated the concern and proceeded to explore the electronic IC program. RN V was able to add McGeer's criteria to the electronic line list. Review of the electronic line list revealed four Residents were listed as not meeting criteria for treatment. Review of the monthly summary for March 2024 revealed Residents who had received treatment without meeting criteria had not been addressed. When queried, RN V' verbalized they would need to incorporate that data and information. Unsampled Resident A was reviewed. Per the line list, Unsampled Resident A was admitted on [DATE] and had a HAI (Healthcare-associated Infection) UTI due to Staphylococcus Aureus (bacteria - rare cause of UTI) with an onset date of 3/2/24. The UA with culture and sensitivity for Unsampled Resident A was requested and reviewed. Per the report, the urine sample was obtained on 2/28/24, received on 2/29/24, and the final report date was 3/4/24. When queried if the onset set of 3/2/24 was the date the antibiotics were initiated, RN V indicated it was. RN V was then asked when the Resident began to have signs/symptoms of infection but was unable to provide a response without completing a comprehensive review of the Resident's EMR. Another Unsampled Resident (B) was listed as being admitted on [DATE] and having a community acquired UTI with E-coli and an onset date of 3/15/24. The comment section of the list indicated the Resident was started on ABX (antibiotics) UTI without catheter but did specify what antibiotic Unsampled Resident B had received. When queried, RN V provided the laboratory report which revealed the urine sample was collected on 3/12/24, received on 3/13/24, and reported on 3/14/24. When asked if the onset date of 3/15/24 was when the Resident was started on antibiotics, RN V confirmed it was. When asked why they were not started on 3/14/24 when the report was received and why the antibiotic was not included on the line list, an explanation was not provided. RN V was then asked how they are tracking Residents with potential infections and/or potential contagious microorganisms and stated, I'm not. When queried regarding the mitigation of spread of illness and surveillance of potential illness, RN V verbalized understanding and revealed they had only tracked antibiotics because they did not know they needed to track potential infections. When queried regarding the importance of symptom onset date in tracking and mitigation, RN V verbalized understanding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When queried regarding employee call in/illness tracking and surveillance, RN V displayed a list of seven employee call ins for March 2024. The list did not include details of the reason for the call in related to illness for infection tracking. When queried regarding the lack of information, RN V revealed they were implementing a new process to ensure they receive information related to infections for tracking and surveillance. When queried if the facility has contracted staff, RN V replied they believed Therapy and dietary staff are contracted. RN V was then asked how they are notified of contracted staff call ins/illness and stated, I don't know. RN V revealed no therapy and/or dietary staff had been included on the call in/employee illness documentation they had received. When queried regarding tracking of Resident covid, influenza and pneumococcal vaccination status, RN V stated, I only have a spreadsheet for covid, not for flu or pneumonia. RN V reiterated they started a month ago. When queried regarding their plan for influenza and pneumococcal vaccinations, RN V stated, I am going to say once it hits flu season, we will start all over again. When queried regarding the pneumococcal vaccine including how often what vaccine is recommended, RN V revealed they were unsure. RN V was then asked if the laundry is sent out or done in the facility and replied in the facility. When queried regarding process surveillance and rounding, RN V revealed they were just getting started and had completed minimal process surveillance and audits. When queried regarding process surveillance/rounding and involvement with laundry services, RN V replied, Not involved with laundry and revealed they had not been to the laundry area/room of the facility. A tour of the laundry area/room was attempted to be complete with RN V at this time, but the room was locked. A tour of the utility room in the Resident hallway was completed. A sign of the door of the utility room stated, PPE (Personal Protective Equipment) stored inside. Upon entering the room, it appeared to be the soiled utility. The room was visibly dirty, malodorous, and cluttered with oxygen concentrators jammed together around the hopper sink. There were cupboards in the room that were unable to be accessed due to various equipment all over the room. When queried if it was the soiled utility room, RN V confirmed it was. RN V was asked about the sign indicating PPE was stored in the room and revealed PPE should not be in the dirty utility. RN V was unable to provide an explanation for the signage on the door. Upon request, a tour of the clean utility room was completed. Boxes of oral supplement drinks were observed sitting directly on the floor. There were oxygen concentrators in the room, some were covered with plastic bags, and some were uncovered and exposed. Some medical supplies were stored haphazardly in old appearing wood style closed door cabinets. When queried regarding the oxygen concentrators, RN V revealed the concentrators should be covered with plastic after being cleaned. When asked why some where uncovered, RN V was unable to provide an explanation. When queried regarding the nutritional supplements on the floor and other observed medical supplies, RN V stated, Not okay. An interview was completed with the Director of Nursing (DON) on 5/1/24 at 10:24 AM. When queried regarding facility policy/procedure for contracted employee call ins, the DON stated, I guess I am not sure and indicated a process/procedure would be implemented. When queried regarding concerns identified in the facility IC program review, the DON verbalized that RN V was new to the role and had not completed training. No further explanation was provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided policy/procedure entitled, Infection Prevention and Control Program (Reviewed/Revised: 12/27/23) revealed, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases . 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement . b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment Performance Improvement. c. Licensed nurses participate in surveillance through assessment/evaluation of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections . 6. Antibiotic Stewardship: a. An antibiotic stewardship program should be implemented as part of the overall infection prevention and control program. b. Antibiotic use protocols and a system to monitor antibiotic use should be implemented as part of the antibiotic stewardship program . 7. Influenza, Pneumococcal and Respiratory Syncytial Virus (RSV) Immunization: a. Residents are offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. b. Residents are offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere . 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection . Review of facility provided policy/procedure entitled, Infection Surveillance (Reviewed/Revised: 10/26/23) revealed, Policy: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections, monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections . 5. Surveillance activities will be monitored facility-wide, and may be broken down by department or unit, depending on the measure being observed. A combination of process and outcome measures will be utilized . 6. The facility will collect data to properly identify possible communicable diseases or infections before they spread . 8. All resident infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. Outbreaks will be investigated. 9. Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks .