STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsdale CO Medical Care Faci	140 W Mechanic St Hillsdale, MI 49242

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to assess for the use of a possible physical restraint for two (Resident #96 and #118) of two reviewed. Findings include: Resident #96 (R96): Review of the medical record reflected R96 admitted to the facility on [DATE], with diagnoses that included Parkinson's disease, neurocognitive disorder with Lewy Bodies and diabetes. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/15/24, reflected R96 scored 10 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/03/24 at 10:08 AM, R96 was observed seated in a recliner, in their room. Both of R96's legs were elevated on the recliner leg rest. R96 reported they were unable to control the leg rest of the recliner chair due to the remote control being located behind the back of the chair. R96 reported they were placed in the recliner after breakfast that morning, between 8:00 AM to 8:30 AM. On 12/05/24 at 10:36 AM, R96 was observed seated in a recliner, in their room. Both of R96's legs were elevated on the recliner leg rest. The recliner remote control was hanging behind the back of the chair. On 12/06/24 at 9:46 AM, R96 was observed seated in their recliner, with the leg rest elevated. The remote control for the recliner was hanging behind the back of the recliner. During an interview on 12/06/24 at 9:26 AM, Certified Nurse Aide (CNA) Q reported R96 transferred with the assistance of two people and used a mechanical lift as needed. CNA Q reported R96 was unable to control the leg rest of their recliner, as the remote control was kept behind the chair. CNA Q reported R96 could operate the recliner chair, but staff did not give R96 the remote control because they did not want R96 to stand and fall. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/24 at 9:48 AM, Registered Nurse (RN) R reported R96 could probably control the leg rest of their recliner, if they wanted to. RN R believed the remote control for R96's recliner was kept on the back of the recliner. RN R reported if R96 had the remote control for their recliner, they may get up and self-transfer. A Physician's Order, with a revision date of 10/24/24, reflected R96's bed and recliner controls were to be kept out of reach for safety. During an interview on 12/06/24 at 11:06 AM, Director of Nursing (DON) B reported keeping the controls out of reach was for fall prevention. DON B reported they did not want the recliner chair raised to a lifting position and potentially having the resident fall forward and hit their head. When asked if there was an assessment to determine if keeping the controls out of reach could be considered a restraint, DON B reported therapy did an assessment. A verbal request for the assessment was made by the State Agency. During an interview on 12/06/24 at approximately 11:20 AM, Risk Manager (RM) U reported they had therapy evaluate to determine if the resident could use the controls safely. If they could not, an order was written to keep the controls out of reach. If a resident could reach around and get in the side pocket of their chair, the remote control was placed behind the chair. RM U reported the rationale for keeping R96's recliner remote behind the chair was because R96 had raised the chair and slid out of it. On 12/10/24 at 11:01 AM, and email request was sent to Nursing Home Administrator (NHA) A for any restraint assessments and therapy notes/assessments pertaining to restraints or the use of a recliner for R96 in the past 12 months. The documentation provided did not reflect that R96 had been assessed for safe use of the recliner remote control or to determine whether keeping the recliner remote control out of reach was a possible restraint. 46954 Resident #118 Review of the medical record revealed R118 admitted to the facility on [DATE] with diagnoses that included history of falling and dementia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/24 revealed R118 scored 3 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/05/24 09:54 AM R118 was observed sleeping in recliner. R118 was dressed and nicely groomed. Review of a General Nursing Note dated 4/26/2024 at 7:50 PM revealed .was speaking with nurse in hallway, heard a loud thumping noise, entered room to see resident (R118) sitting on floor attempting to return PC (personal chair) to upright position by pushing the foot section closed. Asked resident what happened and she laughed stating I couldn't put this down so I climbed out so I could push it . Manual PC removed. electric lift chair placed in room with controls out of reach. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Secure Conversation dated 4/26/2024 at 8:06 PM revealed Resident (R118) fell at 1945 (7:45 PM), unwitnessed resident states she did not fall she climbed out of PC (personal chair) and was trying to shut the footstool . PC to be removed and replaced with electric PC . The author of the note was identified as Licensed Practical Nurse (LPN) AA. In an interview on 12/5/24 at 4:27 PM, LPN AA stated that she remembered R118 and that R118 fell a lot. Regarding the fall out of the recliner chair, LPN AA stated that R118 climbed out of the recliner chair because she could not get out due to the footrest being elevated. LPN AA confirmed that the chair was a personal reclining chair with a manual handle to raise and lower the footrest portion of the recliner chair. LPN AA stated that the intervention for that fall was to replace her manual recliner chair with an electric reclining chair and hid the remote (remote to control the footrest portion of the chair) to keep her in the chair and maintain her safety. LPN AA stated that it was common practice to hide the chair controls behind the chair. Review of a Physician Order revealed an active order which stated PC (personal recliner chair) controls out of reach re: safety. The order was initiated on 5/2/24. In an interview on 12/05/24 at 1:47 PM Licensed Practical Nurse (LPN) BB stated that she was familiar with R118. LPN AA recalled when R118 had a fall out of her personal recliner chair back in August 2024 after R118 stood from her personal reclining chair. R118 will attempt to stand and walk however, does not realize that she cannot ambulate independently anymore. LPN BB reported that the footrest of the recliner chair was down at the time. LPN AA stated that she does not like the footrest of the chairs being up because it creates extra hazards if the residents try to climb out of their personal chair. In an interview on 12/05/24 at 4:20 PM, Licensed Practical Nurse (LPN) CC stated that he was familiar with R118. At the time of her original fall, LPN CC verified that R118 made several attempts to independently ambulate and would often self transfer or attempt to ambulate without staff assistance or assistive devices. In an interview on 12/06/24 at 11:23 AM Licensed Practical Nurse (LPN) U stated that she was familiar with R118's fall out of the recliner and verified R118 crawled out of the recliner. LPN U was unsure if the footrest was up, but she stated she would assume so. LPN U stated that the manual recliner chair was replaced with an electric recliner chair with a remote to control the footrest portion, and a therapy evaluation was requested to determine if R118 was able to safely control the recliner chair footrest. If the resident cannot safely control the chair, an order is placed to keep the chair controls out of reach. LPN U stated that if any resident is not able to control the footrest of the recliner chair, the footrest of the recliner chair should not be up because it can create a safety risk. During an interview on 12/06/24 at 11:06 AM, Director of Nursing (DON) B reported keeping the controls out of reach was for fall prevention. DON B reported they did not want the recliner chair raised to a lifting position and potentially having the resident fall forward and hit their head. When asked if there was an assessment to determine if keeping the controls out of reach could be considered a restraint, DON B reported therapy did an assessment. A verbal request for the assessment was made by the State Agency. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 11:01 AM, and email request was sent to Nursing Home Administrator (NHA) A for any restraint assessments and therapy notes/assessments pertaining to restraints or the use of a recliner for R118 in the past 12 months. The documentation provided did not reflect that R118 had been assessed for safe use of the recliner remote control or to determine whether keeping the recliner remote control out of reach was a possible restraint.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on observations/interviews/record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for four out of four residents (Residents #31, 55, 326, & 478). Findings Included: Resident #31 (R31): Record review of R31's Minimum Data Set (MDS) dated [DATE], revealed R31 had a Brief Assessment for Mental Status (BIMS) score of 12 out of 15 which revealed moderate cognitive impairment. Review of R31's care plans revealed R31 had the potential to be verbally, sexually inappropriate during care. The care plan was initiated on 3/2/2021, and revised on 11/18/2024. The interventions listed on the care plan included, When doing personal cares, redirect when resident makes comments that are sexual in nature and document., dated 10/9/2024. Another intervention in place was to redirect R31 when inappropriate comments were made by R31 that were sexual in nature. The intervention was dated 11/18/2024. Review of R31's electronic medical record (EMR) dated 11/19/2024, revealed, .when in her room checking her catheter and drain bag resident was on the phone telling the other person (male voice) I am on Levaquin (antibiotic) because they were molesting me, they do other stuff to me also but because they are molesting me now I have a UTI (urinary tract infection). social work and supervisor notified. Further review of R31's EMR progress notes dated 11/19/2024 at 12:38 PM, revealed R31's son was notified of R31's statement. It was documented that R31's son stated She's (R31) on and off her rocker. It was documented in the progress note, Administrator was immediately notified of resident statement . Administrator A was requested to provide all incident reports for R31 for the last year. One incident report was received which was not related to R31's statement of being molested. In an interview on 12/10/2024 at 11:52 AM, Administrator A stated yes he recalled the allegation of R31 stating she was molested. Administrator A stated he was made aware of R31's statement that she had been molested at 12:28 PM on 11/19/2024. Administrator A stated that he did not report R31's allegation, because R31's son was on the phone with R31 when R31 made the statement. Administrator A stated R31's son was able to witness/collaborate that none of what R31 stated had occurred. Administrator A was asked how he knew the date and time the allegation occurred, Administrator S stated it would be documented in the progress notes. However, upon review of R31's progress notes, during Administrator A's interview, the notes revealed R31 did not state a date and time she allegedly was molested. Administrator A stated he did not report the allegation because he felt the son collaborated the allegation did not occur. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34705 Resident #55(R55) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R55 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included right below the knee amputation, difficulty walking, anxiety disorder, diabetic and legally blind. The MDS reflected R55 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. The MDS reflected R55 had no behaviors. During an asseveration and interview on 12/04/24 at 9:45 AM, R55 was laying in bed and appeared able to answer questions without difficulty. R55 reported concern that male resident(named R326) entered her room uninvited several months ago who lived in room [ROOM NUMBER]. R55 reported she was legally blind but could see shadows and hear well. R55 reported after R326 entered her room he went in bathroom then exited bathroom and closed R55 door to hall and approached her and kept getting closer and she started screaming for help and R326 responded, shhhh. R55 reported R326 left room and she informed Licensed Practical Nurse (LPN) JJ of what happened. R55 reported LPN JJ informed her R326 would not hurt her. R55 reported she was scared of R326 and when he entered her room she felt intimidated and uncomfortable by R326. R55 reported Nursing Home Administrator (NHA) A apologized to R55 about incident and reported should have read R326 history prior to admission. R55 reported R326 was discharged 2 days later. Resident #326(R326) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R326 was a [AGE] year old male admitted to the facility on [DATE] through 2/7/24 with diagnoses that included Alzheimer with behavior disturbances, bladder cancer, urinary incontinence, dysphasia, weakness and depression. The MDS reflected R326 had a BIM (assessment tool) score of 00 which indicated his ability to make daily decisions was severely impaired. Review of R326 Psychosocial Notes, dated 1/29/2024 at 12:55 p.m., reflected, SW[social work] Met [named R326] and his guardian [named guardian] in his room in Morning [NAME]. [named R326] was per [named guardian] living on the streets 5 years ago in [NAME] and went to the Martha's house and the last 6 months was at [named guardian] adult foster care home. [Named R326] had a large construction company and a nursery, little else is known at this time. He likes TV, westerns and baseball. He does not follow a routine. He needs assistance showering, wears briefs, does not sleep well at night, loves cupcakes and candy bars. He has not wandered per [named guardian]. SW completed a BIMS, PHQ2-9, Wandering Risk and Trauma assessments. [named R326] was unable to answer most questions and information was given by [NAME] when applicable. [named R326] has a diagnosis of Dementia in other disease classified elsewhere, unspecified severity, with other behavioral disturbance, Alzheimer's disease, unspecified and Insomnia. He is prescribed Remeron, Cymbalta and Melatonin. He is a full code and has no plans to discharge. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R326's Psychosocial Note, dated 1/29/2024 at 4:51 p.m., reflected, Call with [named guardian], guardian regarding medication consent and also behaviors. SW informed that he seemed agitated when she went in to do a BIMS. [named guardian] informed that R326 had no behaviors. If agitated he would go to his room and watch TV. She noted that little kids like him. She informed that she thinks he may be a bit stir crazy as she likes to go out and about with two others that lived in the home on the golf cart. She approved for [NAME] to see psychiatric services. Review of R326 Psychosocial Note, dated 1/30/2024 at 8:05 a.m., reflected, Stopped to check on [named R326] at breakfast. He was getting cup of coffee and food was being served. Staff informed he likes to walk around and they are 1:1 today to ensure he does not wander or go in other's rooms . Review of R326 Alert Note, dated 1/30/2024 at 1:46 p.m., reflected, Resident pulled gait belt off in the bathroom and was making marks to the cna about peeing on her while grabbing the cna. Nurse aware. Review of R326 Nursing Progress Note, dated 2/3/2024 06:08 a.m., reflected, CENA[nurse aid] reported to this writer at approx 0440 this A.M., resident was observed leaving another resident's room. CENA noted that this resident had urinated on the foot pedals of that resident's WC while in her room. Just prior to this happening this resident's was relaxed, lying in his bed with his eyes closed. Resident was toileted throughout the night. Review of R326 Nursing Progress Notes, dated 2/4/2024 at 2:08 a.m., reflected, Shortly after shift change resident was observed coming out of another residents room from across the hall unassisted. Resident was redirected back to his room, toileted et placed in his P.C. A little while later as CNA was attempting to get his duties started, again observed resident in another residents room standing at residents bedside leaning over her. As resident was redirected back to his room he hit CNA in the arm, not hurting CNA but did state, He had quite a hit. Resident again was toileted and resident agreed to lay down. (0000). Call light was given et explained to resident. Resident across the hall was startled by his presence but stated, I'm okay. Supervisor is aware of residents behavior. Review of R326 Nursing Progress Note, dated 2/4/2024 at 1:49 p.m., reflected, Resident has been great on 1st shift cooperative, but resident had a 1:1 which could follow him around and keep him out of other resident's rooms. Great appetite and drinks very well. Review of R326 Nursing Progress Note, dated 2/6/2024 at 5:29 a.m., reflected, Resident is resting in bed quietly. Resident ate a snack prior to going to bed at beginning of shift. Resident was cooperative and pleasant with staff at that time. A couple of hours later resident was observed in resident's room across the hall. Resident redirected and assisted to his personal bathroom, and then back to bed. Resident has been incontinent of bladder since previous void. Resident will not allow staff to wash him, and change pull up at this time. Resident shaking his head no, and lifting legs back onto bed with each attempt. Review of R326 Nursing Progress Note, dated 2/6/2024 at 6:04 a.m., reflected, At approx 0550 this writer observed resident walk quickly across hall to room [ROOM NUMBER] and close the door behind him. This writer immediately went to room [ROOM NUMBER] to redirect this resident out of the other resident's room. Resident was attempting to pull his pants down to urinate on the floor. Resident stated I'm not going anywhere. Resident eventually allowed staff to assist him back to his room. Resident then urinated on his bathroom floor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R326 Psychosocial Note, dated 2/7/2024 at 11:50 a.m., reflected, Call with [named case worker], (name of county) APS[adult protective services] to gain background information. She informed that neighboring county and current county Lifeways served [named R326] in the past along with information about his previous residence. She informed he was a chain smoker as well. Review of R326 Psychosocial Note, dated, 2/7/2024 at 1:04 p.m., reflected, Notified that [named R326] was quite agitated; CNA[certified nurse aid] with him and needed assistance. [named R326] was making remarks he was getting out of here, others are trying to kill him, he won't let that happen along with him continually blowing air out of his mouth, with a very agitated look on his face. Was not able to redirect his agitation but walked with him as he quickly wheeled himself all over first floor a few times. He attempted to go toward front door with 2 SW[social worker] and Administrator redirecting him back toward his neighborhood. SW and CNA took to room, offered lunch and eventually [named R326] came to nurses station and CNA brought another lunch and he ate having eventually calming down. Therapy took to bathroom and then to walk. Review of R326 Nursing Progress Note, dated, 2/7/2024 at 1:32 p.m., reflected, This am supervisor was walking by resident's room and he was standing at the end of his bed urinating on the floor. Resident redirected and reminded we use the restroom (Showed him the bathroom sign and the bathroom) we do not pee on the floor. After breakfast CNA tried to toilet resident but he did not go, he then set in his PC[personal chair] watching television as the daughter of the neighbor across the hall came out in the hall and said this gentleman had his penis out. Nurse went in to check on resident and he was master baiting with the door open. Nurse made sure he was safe and shut his door for privacy, CNA went in to check on him and clean him up. Resident was in his w/c just before lunch propelling himself around with staff walking with him keeping him out of others rooms, when trying to redirect resident out of rooms he started to swing his fist at staff. Supervisor, Social Worker notified and helped with resident. Review of R326 Nursing Progress Note, dated 2/7/2024 at 5:20 p.m., reflected, Guardian [named] here for transfer of care. Med list gone over, discharge paperwork signed. Wander guard removed from right ankle. Staff assisted to car. During a telephone interview on 12/05/24 at 2:50 PM, Licensed Practical Nurse(LPN) FF reported if resident exposed self to others would notify nurse manager and/or Social Worker because could be behavior. LPN FF reported could be allegation of abuse and would report to nurse manager and Nursing Home Administrator(NHA) immediately. During an interview on 12/10/24 at 8:55 AM, LPN JJ reported had worked at the facility for several years. LPN JJ reported R55 did report male resident in her room and verified R326 used to wander and urinate in other resident rooms. LPN JJ reported R55 appeared upset after male resident entered her room uninvited by the way R55 was acting. LPN JJ reported contacted the supervisor, director of nursing(DON), and NHA. LPN JJ reported R326 was not resident for long and staff had to keep close eye on R326 related to frequent wandering in other resident rooms. LPN JJ reported R326 had prior history of being demented. LPN JJ reported if resident exposed self to others could be allegation of sexual abuse, after first stating, if not touched, no. LPN JJ was then asked, do they need to be touched to be allegation of sexual abuse, no. LPN JJ reported if unwanted exposure would be allegation of sexual abuse and would contact supervisor, DON and NHA immediately who determine if investigation was needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 10:14 AM, Social Worker KK reported had worked at facility over a year. SW KK reported was responsible for residents on [NAME] Lane and Morning [NAME] units including R55. SW KK reported would follow up with residents after allegation of abuse to assess psychosocial well being and verify residents feel safe. SW KK reported described R326 as gentle giant with possible history of traumatic brain injury. SW KK reported R326 behaviors(wander in other resident rooms, and urinating in public exposing self) caused several female residents anxiety and felt intimidated by R326 size. SW KK stated, [named R326] being at facility was traumatic for several women, he had the look like he was looking through you. SW KK reported R326 was not a good fit for the facility. SW KK reported R326 was discussed in morning meeting on 2/5/24 through 2/7/24 and verified was on vacation 2/1/24 through 2/4/24. SW KK verified was unable to locate follow up documentation in R55 chart post incident, when R326 entered resident room uninvited, but recalls speaking with resident and reported should have documented. No Facility Reported Incidents related to R326 were located in the reporting system. A request for Incident reports revealed no incidents related to the abuse allegations. During an interview on 12/10/24 at 11:20 AM, Nursing Home Administrator(NHA) A reported had worked at the facility for [AGE] years and had been the abuse coordinator for the past five years. NHA A reported staff expected to report allegations of abuse immediately to direct supervisor or NHA. NHA A reported facility policy to report allegations of abuse within 2 hours if physical injury and 24 hours if no injury and SW staff involved investigations. NHA A reported R326 did not have any reported allegations of abuse. NHA A was queried if he had any knowledge of residents who felt intimidated or uncomfortable with R326 or and incidents of R326 exposing private areas to other residents. NHA A reported did not think R326 was willful with his actions. NHA A reported would expect staff to report if resident felt threatened or fearful of another resident including when R326 entered R55 room uninvited. NHA A reported incident was not reported to the state of Michigan and was unable to day why. During an interview on 10/10/24 at 1:40 p.m., NHA A reported after review of R326 medical record verified R326 entered R55 several times uninvited and verified should have been reported and SW should have followed up with both residents involved. 46954 Resident 478 (R478) Review of the medical record revealed R478 admitted to the facility on [DATE] with diagnoses that included dementia and Alzheimer's disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/24 revealed R478 scored 7 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/03/24 at 11:38 AM, R478 was observed at the dining room table. R478 did not respond to an interview attempt. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Behavior Note dated 5/31/2024 reflected R478 refused weekly shower; bed bath given by male cena [certified nursing assistant] much to res's [residents] dismay. Res [resident] hollering during care, this writer went in to assist cena [certified nursing assistant] in finishing the bed bath, res [resident] threatening to slap cena [certified nursing assistant] in the face for molesting her. Res [resident] kept protesting and calling for nurse despite this writer standing at the side of the bed helping. After cena [certified nursing assistant] and this writer left res's [residents'] room she continued to holler out for a few minutes . The author of the note was identified as Registered Nurse (RN) K. In an interview on 12/05/24 at 3:53 PM, Registered Nurse (RN) K was very defensive and uncooperative with questioning regarding the documented allegation. RN K stated that if that allegation was something that she would have had reported to her, she would have notified the abuse coordinator as soon as possible. Review of a Behavior note dated 9/7/2024 revealed Resident (R478) was delusional and paranoid this shift. Wanted staff with her at all times because she was frightened. When asked what she was frightened of pt. (R478) responded that first shift staff was mean to her .Begged this nurse to stay with her because she needed protection. Then begged male CENA [certified nursing assistant] to stay with her. Each time that staff left her side, she then stated that each person was mean to her, that this nurse called her names, that male CENA [certified nursing assistant] and his gangsters (referring to staff) were going to hurt her and that she was going to beat him with her beating stick. Repeated several times that staff was going to try to kill her and every resident here .When put to bed, resident was a bit calmer but still paranoid. The author of this note was identified as Registered Nurse (RN) L. In an interview on 12/05/24 at 3:15 PM, RN L reported that it was a common occurrence that R478 displayed feelings of paranoia and made accusations that staff were mean to her or performed care in a matter that was sexual. In an interview on 12/05/24 at 2:47 PM, Licensed Practical Nurse (LPN) F reported that R478 occasionally makes comments about staff being mean to her or hurting her while providing care, which LPN K passes along to management for follow up. No Facility Reported Incidents related to R478 were located in the reporting system. A request for Incident reports revealed no incidents related to the abuse allegations. In an interview on 12/10/24 at 11:21 AM, Nursing Home Administrator (NHA) A stated that the expectation for allegations of any kind of abuse would be reported immediately to him so that he could conduct an investigation. NHA A denied any knowledge of R478's allegations and stated that the allegations would have required to be reported to the State Agency and perform an investigation.

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Hillsdale CO Medical Care Faci	140 W Mechanic St Hillsdale, MI 49242

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on interview and record review the facility failed to, investigate allegations of abuse for four out of four residents (Residents #31, 55, 326, & 478). Findings Included: Resident #31 (R31): Record review of R31's Minimum Data Set (MDS) dated [DATE], revealed R31 had a Brief Assessment for Mental Status (BIMS) score of 12 out of 15 which revealed moderate cognitive impairment. Review of R31's care plans revealed R31 had the potential to be verbally, sexually inappropriate during care. The care plan was initiated on 3/2/2021, and revised on 11/18/2024. The interventions listed on the care plan included, When doing personal cares, redirect when resident makes comments that are sexual in nature and document., dated 10/9/2024. Another intervention in place was to redirect R31 when inappropriate comments were made by R31 that were sexual in nature. The intervention was dated 11/18/2024. Review of R31's electronic medical record (EMR) dated 11/19/2024, revealed, .when in her room checking her catheter and drain bag resident was on the phone telling the other person (male voice) I am on Levaquin (antibiotic) because they were molesting me, they do other stuff to me also but because they are molesting me now I have a UTI (urinary tract infection). social work and supervisor notified. Further review of R31's EMR progress notes dated 11/19/2024 at 12:38 PM, revealed R31's son was notified of R31's statement. It was documented that R31's son stated She's (R31) on and off her rocker. It was documented in the progress note, Administrator was immediately notified of resident statement . Administrator A was requested to provide all incident reports for R31 for the last year. One incident report was received which was not related to R31's statement of being molested. In an interview on 12/10/2024 at 11:52 AM, Administrator A stated yes he recalled the allegation of R31 stating she was molested. Administrator A stated he was made aware of R31's statement that she had been molested at 12:28 PM on 11/19/2024. Administrator A stated that he did not investigate R31's allegation, because R31's son was on the phone with R31 when R31 made the statement. Administrator A stated R31's son was able to witness/collaborate that none of what R31 stated had occurred. Administrator A was asked how he knew the date and time the allegation occurred, Administrator S stated it would be documented in the progress notes. However, upon review of R31's progress notes, during Administrator A's interview, the notes revealed R31 did not state a date and time she allegedly was molested. Administrator A stated he did not investigate the allegation because he felt the son collaborated the allegation did not occur. 34705 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #55(R55) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R55 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included right below the knee amputation, difficulty walking, anxiety disorder, diabetic and legally blind. The MDS reflected R55 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. The MDS reflected R55 had no behaviors. During an asseveration and interview on 12/04/24 at 9:45 AM, R55 was laying in bed and appeared able to answer questions without difficulty. R55 reported concern that male resident(named R326) entered her room uninvited several months ago who lived in room [ROOM NUMBER]. R55 reported she was legally blind but could see shadows and hear well. R55 reported after R326 entered her room he went in bathroom then exited bathroom and closed R55 door to hall and approached her and kept getting closer and she started screaming for help and R326 responded, shhhh. R55 reported R326 left room and she informed Licensed Practical Nurse (LPN) JJ of what happened. R55 reported LPN JJ informed her R326 would not hurt her. R55 reported she was scared of R326 and when he entered her room she felt intimidated and uncomfortable by R326. R55 reported Nursing Home Administrator (NHA) A apologized to R55 about incident and reported should have read R326 history prior to admission. R55 reported R326 was discharged 2 days later. Resident #326(R326) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R326 was a [AGE] year old male admitted to the facility on [DATE] through 2/7/24 with diagnoses that included Alzheimer with behavior disturbances, bladder cancer, urinary incontinence, dysphasia, weakness and depression. The MDS reflected R326 had a BIM (assessment tool) score of 00 which indicated his ability to make daily decisions was severely impaired. Review of R326 Psychosocial Notes, dated 1/29/2024 at 12:55 p.m., reflected, SW[social work] Met [named R326] and his guardian [named guardian] in his room in Morning [NAME]. [named R326] was per [named guardian] living on the streets 5 years ago in [NAME] and went to the Martha's house and the last 6 months was at [named guardian] adult foster care home. [Named R326] had a large construction company and a nursery, little else is known at this time. He likes TV, westerns and baseball. He does not follow a routine. He needs assistance showering, wears briefs, does not sleep well at night, loves cupcakes and candy bars. He has not wandered per [named guardian]. SW completed a BIMS, PHQ2-9, Wandering Risk and Trauma assessments. [named R326] was unable to answer most questions and information was given by [NAME] when applicable. [named R326] has a diagnosis of Dementia in other disease classified elsewhere, unspecified severity, with other behavioral disturbance, Alzheimer's disease, unspecified and Insomnia. He is prescribed Remeron, Cymbalta and Melatonin. He is a full code and has no plans to discharge. Review of R326 Psychosocial Note, dated 1/29/2024 at 4:51 p.m., reflected, Call with [named guardian], guardian regarding medication consent and also behaviors. SW informed that he seemed agitated when she went in to do a BIMS. [named guardian] informed that R326 had no behaviors. If agitated he would go to his room and watch TV. She noted that little kids like him. She informed that she thinks he may be a bit stir crazy as she likes to go out and about with two others that lived in the home on the golf cart. She approved for [NAME] to see psychiatric services. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R326 Psychosocial Note, dated 1/30/2024 at 8:05 a.m., reflected, Stopped to check on [named R326] at breakfast. He was getting cup of coffee and food was being served. Staff informed he likes to walk around and they are 1:1 today to ensure he does not wander or go in other's rooms . Review of R326 Alert Note, dated 1/30/2024 at 1:46 p.m., reflected, Resident pulled gait belt off in the bathroom and was making marks to the cna about peeing on her while grabbing the cna. Nurse aware. Review of R326 Nursing Progress Note, dated 2/3/2024 06:08 a.m., reflected, CENA[nurse aid] reported to this writer at approx 0440 this A.M., resident was observed leaving another resident's room. CENA noted that this resident had urinated on the foot pedals of that resident's WC while in her room. Just prior to this happening this resident's was relaxed, lying in his bed with his eyes closed. Resident was toileted throughout the night. Review of R326 Nursing Progress Notes, dated 2/4/2024 at 2:08 a.m., reflected, Shortly after shift change resident was observed coming out of another residents room from across the hall unassisted. Resident was redirected back to his room, toileted et placed in his P.C. A little while later as CNA was attempting to get his duties started, again observed resident in another residents room standing at residents bedside leaning over her. As resident was redirected back to his room he hit CNA in the arm, not hurting CNA but did state, He had quite a hit. Resident again was toileted and resident agreed to lay down. (0000). Call light was given et explained to resident. Resident across the hall was startled by his presence but stated, I'm okay. Supervisor is aware of residents behavior. Review of R326 Nursing Progress Note, dated 2/4/2024 at 1:49 p.m., reflected, Resident has been great on 1st shift cooperative, but resident had a 1:1 which could follow him around and keep him out of other resident's rooms. Great appetite and drinks very well. Review of R326 Nursing Progress Note, dated 2/6/2024 at 5:29 a.m., reflected, Resident is resting in bed quietly. Resident ate a snack prior to going to bed at beginning of shift. Resident was cooperative and pleasant with staff at that time. A couple of hours later resident was observed in resident's room across the hall. Resident redirected and assisted to his personal bathroom, and then back to bed. Resident has been incontinent of bladder since previous void. Resident will not allow staff to wash him, and change pull up at this time. Resident shaking his head no, and lifting legs back onto bed with each attempt. Review of R326 Nursing Progress Note, dated 2/6/2024 at 6:04 a.m., reflected, At approx 0550 this writer observed resident walk quickly across hall to room [ROOM NUMBER] and close the door behind him. This writer immediately went to room [ROOM NUMBER] to redirect this resident out of the other resident's room. Resident was attempting to pull his pants down to urinate on the floor. Resident stated I'm not going anywhere. Resident eventually allowed staff to assist him back to his room. Resident then urinated on his bathroom floor. Review of R326 Psychosocial Note, dated 2/7/2024 at 11:50 a.m., reflected, Call with [named case worker], (current county) APS[adult protective services] to gain background information. She informed that neighboring county and current county Lifeways served [named R326] in the past along with information about his previous residence. She informed he was a chain smoker as well. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R326 Psychosocial Note, dated, 2/7/2024 at 1:04 p.m., reflected, Notified that [named R326] was quite agitated; CNA[certified nurse aid] with him and needed assistance. [named R326] was making remarks he was getting out of here, others are trying to kill him, he won't let that happen along with him continually blowing air out of his mouth, with a very agitated look on his face. Was not able to redirect his agitation but walked with him as he quickly wheeled himself all over first floor a few times. He attempted to go toward front door with 2 SW[social worker] and Administrator redirecting him back toward his neighborhood. SW and CNA took to room, offered lunch and eventually [named R326] came to nurses station and CNA brought another lunch and he ate having eventually calming down. Therapy took to bathroom and then to walk. Review of R326 Nursing Progress Note, dated, 2/7/2024 at 1:32 p.m., reflected, This am supervisor was walking by resident's room and he was standing at the end of his bed urinating on the floor. Resident redirected and reminded we use the restroom (Showed him the bathroom sign and the bathroom) we do not pee on the floor. After breakfast CNA tried to toilet resident but he did not go, he then set in his PC[personal chair] watching television as the daughter of the neighbor across the hall came out in the hall and said this gentleman had his penis out. Nurse went in to check on resident and he was master baiting with the door open. Nurse made sure he was safe and shut his door for privacy, CNA went in to check on him and clean him up. Resident was in his w/c just before lunch propelling himself around with staff walking with him keeping him out of others rooms, when trying to redirect resident out of rooms he started to swing his fist at staff. Supervisor, Social Worker notified and helped with resident. Review of R326 Nursing Progress Note, dated 2/7/2024 at 5:20 p.m., reflected, Guardian [named] here for transfer of care. Med list gone over, discharge paperwork signed. Wander guard removed from right ankle. Staff assisted to car. During a telephone interview on 12/05/24 at 2:50 PM, Licensed Practical Nurse(LPN) FF reported if resident exposed self to others would notify nurse manager and/or Social Worker because could be behavior. LPN FF reported could be allegation of abuse and would report to nurse manager and Nursing Home Administrator(NHA) immediately. During an interview on 12/10/24 at 8:55 AM, LPN JJ reported had worked at the facility for several years. LPN JJ reported R55 did report male resident in her room and verified R326 used to wander and urinate in other resident rooms. LPN JJ reported R55 appeared upset after male resident entered her room uninvited by the way R55 was acting. LPN JJ reported contacted the supervisor, director of nursing(DON), and NHA. LPN JJ reported R326 was not resident for long and staff had to keep close eye on R326 related to frequent wandering in other resident rooms. LPN JJ reported R326 had prior history of being demented. LPN JJ reported if resident exposed self to others could be allegation of sexual abuse, after first stating, if not touched, no. LPN JJ was then asked, do they need to be touched to be allegation of sexual abuse, no. LPN JJ reported if unwanted exposure would be allegation of sexual abuse and would contact supervisor, DON and NHA immediately who determine if investigation was needed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 10:14 AM, Social Worker KK reported had worked at facility over a year. SW KK reported was responsible for residents on [NAME] Lane and Morning [NAME] units including R55. SW KK reported would follow up with residents after allegation of abuse to assess psychosocial well being and verify residents feel safe. SW KK reported described R326 as gentle giant with possible history of traumatic brain injury. SW KK reported R326 behaviors(wander in other resident rooms, and urinating in public exposing self) caused several female residents anxiety and felt intimidated by R326 size. SW KK stated, [named R326] being at facility was traumatic for several women, he had the look like he was looking through you. SW KK reported R326 was not a good fit for the facility. SW KK reported R326 was discussed in morning meeting on 2/5/24 through 2/7/24 and verified was on vacation 2/1/24 through 2/4/24. SW KK verified was unable to locate follow up documentation in R55 chart post incident, when R326 entered resident room uninvited, but recalls speaking with resident and reported should have documented. No Facility Reported Incidents related to R326 were located in the reporting system. A request for Incident reports revealed no incidents related to the abuse allegations. During an interview on 12/10/24 at 11:20 AM, Nursing Home Administrator(NHA) A reported had worked at the facility for [AGE] years and had been the abuse coordinator for the past five years. NHA A reported staff expected to report allegations of abuse immediately to direct supervisor or NHA. NHA A reported facility policy to report allegations of abuse within 2 hours if physical injury and 24 hours if no injury and SW staff involved investigations. NHA A reported R326 did not have any reported allegations of abuse. NHA A was queried if he had any knowledge of residents who felt intimidated or uncomfortable with R326 or and incidents of R326 exposing private areas to other residents. NHA A reported did not think R326 was willful with his actions. NHA A reported would expect staff to report if resident felt threatened or fearful of another resident including when R326 entered R55 room uninvited. NHA A reported incident was not reported to the state of Michigan and was unable to day why. During an interview on 10/10/24 at 1:40 p.m., NHA A reported after review of R326 medical record verified R326 entered R55 private room several times uninvited and verified should have been reported and investigated and SW should have followed up with both residents involved. 46954 Resident 478 (R478) Review of the medical record revealed R478 admitted to the facility on [DATE] with diagnoses that included dementia and Alzheimer's disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/24 revealed R478 scored 7 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/03/24 at 11:38 AM, R478 was observed at the dining room table. R478 did not respond to an interview attempt. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Behavior Note dated 5/31/2024 reflected R478 refused weekly shower; bed bath given by male cena [certified nursing assistant] much to res's [residents] dismay. Res [resident] hollering during care, this writer went in to assist cena [certified nursing assistant] in finishing the bed bath, res [resident] threatening to slap cena [certified nursing assistant] in the face for molesting her. Res [resident] kept protesting and calling for nurse despite this writer standing at the side of the bed helping. After cena [certified nursing assistant] and this writer left res's [residents'] room she continued to holler out for a few minutes . The author of the note was identified as Registered Nurse (RN) K. In an interview on 12/05/24 at 3:53 PM, Registered Nurse (RN) K was very defensive and uncooperative with questioning regarding the documented allegation. RN K stated that if that allegation was something that she would have had reported to her, she would have notified the abuse coordinator as soon as possible. Review of a Behavior note dated 9/7/2024 revealed Resident (R478) was delusional and paranoid this shift. Wanted staff with her at all times because she was frightened. When asked what she was frightened of pt. (R478) responded that first shift staff was mean to her .Begged this nurse to stay with her because she needed protection. Then begged male CENA [certified nursing assistant] to stay with her. Each time that staff left her side, she then stated that each person was mean to her, that this nurse called her names, that male CENA [certified nursing assistant] and his gangsters (referring to staff) were going to hurt her and that she was going to beat him with her beating stick. Repeated several times that staff was going to try to kill her and every resident here .When put to bed, resident was a bit calmer but still paranoid. The author of this note was identified as Registered Nurse (RN) L. In an interview on 12/05/24 at 3:15 PM, RN L reported that it was a common occurrence that R478 displayed feelings of paranoia and made accusations that staff were mean to her or performed care in a matter that was sexual. In an interview on 12/05/24 at 2:47 PM, Licensed Practical Nurse (LPN) F reported that R478 occasionally makes comments about staff being mean to her or hurting her while providing care, which LPN K passes along to management for follow up. No Facility Reported Incidents related to R478 were located in the reporting system. A request for Incident reports revealed no incidents related to the abuse allegations. In an interview on 12/10/24 at 11:21 AM, Nursing Home Administrator (NHA) A stated that the expectation for allegations of any kind of abuse would be reported immediately to him so that he could conduct an investigation. NHA A denied any knowledge of R478's allegations and stated that the allegations would have required to be reported to the State Agency and perform an investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to implement care planned interventions for one (Resident #13) and develop a comprehensive care plan for one (Resident #478) of two reviewed. Findings include: Resident #13 (R13): Review of the medical record reflected R13 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included stage two pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) of the sacral region (7/5/24) and Alzheimer's. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/6/24, reflected R13 scored eight out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and had a facility-acquired stage two pressure ulcer. R13's Care Plan reflected they had an air mattress to assist with pressure reduction. On 12/03/24 at 10:55 AM, R13 was observed lying in bed, on their back. An air mattress pump was observed hanging on the foot board of the bed. The power switch was in the on position, however, the lights on the pump were not illuminated, indicating the air mattress pump was not on and/or functioning. R13 reported they had a wound on their buttocks that was being treated. On 12/06/24 at 10:13 AM, R13 was observed lying in bed. The air mattress pump, hanging on the foot of the bed, was observed with the power switch in the on position. There were no lights illuminated on the pump, indicating the air mattress was not on and/or functioning. The power cord from the mattress pump was observed partially unplugged from the wall outlet. During an interview on 12/05/24 at 10:43 AM, Licensed Practical Nurse (LPN) M reported R13's interventions to facilitate wound healing included an air mattress. Regarding how they would determine if the air mattress was on and functioning, LPN M reported they looked at the mattress when they went into the room and could tell if it was on. LPN M reported they also listened for alarms, stating the mattress would alarm if there was low pressure or if it was not plugged in. During an interview on 12/06/24 at 10:15 AM, when asked how staff knew if an air mattress was functioning, Certified Nurse Aide (CNA) S stated that was a good question. CNA S reported CNAs did not do anything with air mattresses, but sometimes, they could hear the mattresses functioning. During an interview and observation that began on 12/06/24 at 10:39 AM, Wound Care Nurse Practitioner (NP) T and Wound Care Registered Nurse (RN) O reported R13 had an air mattress. Upon inspection of R13's air mattress and pump, RN O stated someone had turned the air mattress off. They then noted the air mattress pump was partially unplugged from the wall. RN O felt R13's air mattress and reported it had lost some air since they had been in R13's room around 5:00 AM that morning. NP T and RN O were uncertain who was responsible for ensuring the air mattress was on/functioning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46954 Resident 478 (R478) Review of the medical record revealed R478 admitted to the facility on [DATE] with diagnoses that included dementia and Alzheimer's disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/24 revealed R478 scored 7 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/03/24 at 11:38 AM, R478 was observed at the dining room table. R478 did not respond to an interview attempt. Review of a Secure message dated 8/9/2024 reflected R478 was experiencing paranoia and was attempting to exit the facility. Review of a Behavior Note dated 9/21/at 7:56 PM revealed R478 was actively exit seeking to patio door trying to get out of the building did propel self up to the front of the building wanting to go home refused to lay down states she is worried something happened to her husband attempted to redirect several times. Review of a Behavior Note dated 9/25/2024 at 8:22 PM revealed R478 was exit seeking this shift . Review of a Secure Conversation dated 9/28/2024 at 8:20 PM revealed R478 was once again, exit seeking. Review of a Behavior Note dated 11/24/2024 at 1:39 PM revealed R478 propelled self from the dining room table calling out help for staff sitting in front of egress door to the porch trying to open the door and asking for staff to push her outside her son is out there in his car unable to redirect left alone able to redirect laid down for a rest period on 2-10 pm shift exit seeking lasted 40 minutes. In an interview on 12/05/24 at 3:15 PM, RN L reported that it was a common occurrence that R478 displayed feelings of paranoia and would exit seek. RN L stated that the facility was not outfitted with a wanderguard alarm system so the staff would try and catch the behavior so that they could lock the front door of the facility to prevent R478 from exiting. In an interview on 12/05/24 at 2:47 PM, Licensed Practical Nurse (LPN) F reported that R478 occasionally exit seeks however, the exit seeking had increased in the past few months. LPN F confirmed that there was no wanderguard system in the facility where R478 resided, so staff did their best to maintain R478's safety by locking the front doors to the facility. In an interview on 12/06/24 at 9:49 AM, Registered Nurse (RN) R stated that she has observed R478 exit seeking on several occasions. In an interview on 12/06/24 at 10:15 AM, Social Work (SW) Z stated that she had just recently learned that R478 had been exit seeking so she added it to the care plan yesterday. (continued on next page)

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Hillsdale CO Medical Care Faci	140 W Mechanic St Hillsdale, MI 49242

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R478's care plan revealed that an exit seeking care plan was developed on 12/2/24, despite displaying exit seeking behavior for months prior. In an interview on 12/10/24 at 12:13 PM , Director of Nursing (DON) B stated that if a resident was displaying exit seeking behavior, she would expect to see that care planned.

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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** 34705 Based on observation, interview and record review the facility failed to: 1.) ensure the safety of resident during staff assisted transfer, and 2.) implement care-planned interventions for 1 of 4 sampled residents (R6) reviewed for accidents, resulting in actual harm for R6's fall during staff assisted transfer with bilateral pelvic fractures, a fractured left elbow, and a non displaced fracture near her left total hip site on 3/10/24 and 10/21/24 that required transfer to the hospital. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R6 was a [AGE] year old female admitted to the facility on [DATE], with re-admission post hospital admission 3/12/24 following left pelvic fractures, a fractured left elbow, and a non displaced fracture near her left total hip site, and 10/23/24 post fall with a left lesser trochanter fracture which is non-operable with other diagnoses that included history left hip replacement, heart failure, hypertension(high blood pressure), diabetic, Osteoarthritis, heart disease, chronic lung disease, anxiety and depression. The MDS reflected R6 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was cognitively intact with no behaviors including rejection of care. Continued review of the significant change MDS, dated [DATE], reflected R6 was now bed bound and was dependant on staff for all activities of daily living. During an observation and interview on 12/03/24 at 9:14 AM, R6 door was closed. R6 was laying in bed wearing a hospital gown, call light out of reach resting on oxygen concentrator about three feet from bed. R6's fitted sheet was under R6 but not over edges of air mattress with odor of BM(bowel movement) in room. R6 appeared able to answer questions without difficulty and reported would use call light to get staff assistance if needed. During an observation on 12/03/24 at 10:20 AM, R6 door closed and call light continued to be out of reach, now on the floor under resident bed. R6 eyes closed laying in bed. During an observation and interview on 12/03/24 at 12:15 PM, R6 door was open and family was R6's daughter DD was present with call light on and within reach. R6 daughter DD reported call light was on because R6 needed assistance with bowel incontinence care. R6 daughter DD reported R6 had foley catheter in place related to since most recent fall with left hip fracture related to Orthopedic order for bed rest and stage 3 pressure wound to sacral area. R6 reported had fall about 6 months ago with several fractures during a staff assisted transfer then an additional fall about two months ago during staff assisted transfer with fracture of left hip. R6 reported pressure wound started at the facility. During an observation on 12/04/24 at 8:45 AM, R6 door was open, resident was sitting upright in bed eating independently dressed in hospital gown with call light out of each under the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Progress note, dated 3/10/2024 at 8:00p.m., reflected, Secure Conversations Messages: Subject: FALL[2024-03-10 19:37:24 EDT] .Resident fell outside bathroom door, witnessed as CNA[Certified Nursing Assistance] was assisting resident. Complains of left hip pain including with ROM[range of motion]. Dr phoned and order to send out to ER for further eval and tx[treatment]. Small hematoma to left side of forehead and bruise to left top of hand . Review of the Nursing Progress note, dated 3/11/2024 at 4:54a.m., reflected, Telephoned [named] Hospital ER[emergency room] and was notified that resident was admitted with hip fracture . Review of the Nursing Progress note, dated 6/22/202 at 2:27 p.m., reflected, Resident observed sitting on the floor in front of her dresser beside her PC[personal chair] leaning back on the dresser, Code 99 called. Assessed resident, no injuries noted. Resident did state,My butt hurts from sitting on the floor. Resident's oxygen was off spo2[oxygen saturation] was 83% on RA[room air], re-applied oxygen immediately before assessing her and spo2 increased to 91% on 2.5 LPM[liters per minute] o2via NC[nasal canula]. Resident assisted in PC via maxi-lift. CNA stated, I was walking resident back from the bathroom and she was off balance so I lowered her to the floor. Resident did not hit her head. CNA did not have F/U[follow up] w/c[wheelchair]behind resident as ordered when ambulating. CNA was given a written verbal warning for resident not having o2[oxygen] on and for not using F/U w/c while ambulating as ordered . Review of the Nursing Progress note, dated 10/21/2024 at 6:39 p.m., reflected, At 1450p[2:50 p.m.] Resident was being transferred from her motor-chair to her personal chair with gait belt on and 2ww[two wheel walker], by this writer, resident lost her balance, and resident fell backwards to the floor. Code 99 called. Upon assessment resident complained of left hip pain, resident not moved and 911 called, resident left by ambulance at 1515pm[3:15 p.m.]. Review of the Nursing Progress note, dated 10/23/2024 at 2:51 p.m., reflected, Admission Summary Note Text: Resident arrived back at facility at 1323[1:23 p.m.] via stretcher accompanied by 2 EMTs[emergency medical technicians] after a fall. Resident has a Left lessor trochanter FX[fracture]. Resident is non-wt bearing, has a 16 Fr Foley catheter. Resident's pain level now is a #7 of 10, Percocet 7. 5/325mg tab given at 1357[1:57 p.m.]. Resident has a stage 3 pressure wound to coccyx that is covered by border foam . Review of the Incident/Accident(I/A) reports provided 12/04/24 at 1:10 PM, revealed R6 had fall with several fractures on 3/10/24 during staff assisted transfer without following interventions including the use of a gait belt. Fall on 6/22/24 during staff assisted transfer without following ordered interventions. Fall on 10/21/24 during staff assisted transfer with left lessor trochanter fracture. Continued review of the I/A reports reflected no witness statements. Director of Nursing (DON) B reported would provided complete investigations. Review of the Fall Assessment, dated 1/21/24, reflected R6 was at high risk for falls with score of 55. Continued review of the Fall Assessment, dated 9/12/24, reflected R6 was at high risk for falls with score of 70. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R6 Care Plan, dated 10/8/2019 to current 12/10/24, reflected, The resident is high risk for falls r/t cardiac issues/anxiety/COPD/muscle weakness/prior history of falls, Macular Degeneration. The Care Plan had interventions that included, Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 12/08/2019 . During a telephone interview on 12/05/24 at 10:37 AM, Certified Nurse Aid (CNA) EE reported was transferring R6 on 3/10/24 when she fell in bathroom. CNA EE reported R6 used walker with one person assist for transfers with gait belt. CNA EE reported R6 did not have gait belt on at the time of the fall because R6 did not like it. CNA EE reported R6 fell hard on left hip and left elbow the hit left side of face on floor just inside bathroom door when R6 insisted CNA EE pick up personal item from the floor. CNA EE reported R6 was in visual pain as evidenced by wincing and guarding and reported pain in left hip and told EMS left elbow. CNA EE reported called for nurse who was just outside R6 door and reported remained with R6 on the floor until EMS arrived 30 minutes to one hour later. CNA EE reported received education after fall to always use gait belt during transfers and if residents refuse to notify nurse prior to transfer. CNA EE reported after 3/10/24 fall R6 transfer status was maxi lift(hoyer) with 2 assist, then to 1 assist with 4ww and gait belt. CNA EE reported R6 was making good recovery after fall and had additional fall with nurse assist about 2 months ago. During a telephone interview on 12/05/24 at 2:39 PM, Licensed Practical Nurse (LPN) FF reported was transferring R6 on 10/21/24 from motorchair to personal chair in room when R6 lost balance and fell backwards on floor. LPN FF reported she was standing beside R6 with gait belt in place and walker in front of R6 when R6 lost balance fell on back on floor. LPN FF reported was unsure if she was holding R6 gait belt by side of the back. LPN FF reported R6 reported severe pain to left leg and could not even stand for left leg to be touched. During a telephone interview on 12/06/24 at 5:06 PM, CNA GG reported was working 3/10/24 when R6 fell . CNA GG reported was the first extra staff to respond to the code 99(fall code). CNA GG reported R6 was laying in doorway of bathroom in room and did not have a gait belt on. CNA GG reported gait belt should always be used during staff assisted transfer and reported had informed nurse manager was not in place. CNA GG reported CNA EE received education after R6 fall related to use of gait belt at all times. During an interview on 12/06/24 at 9:25 AM, Therapy staff HH verified R6 transfer status was one assist with use of walker and gait belt at the time of the 3/10/24 and 10/21/24 fall. During an interview on 12/06/24 at 11:39 AM, LPN II reported was R6 nurse on 3/10/24 and reported had medication cart just outside R6 when she heard crash in R6's room and heard CNA FF say R6 was on the floor. LPN II reported R6 was on the floor, in the bathroom doorway, laying on her back and called code 99. LPN II reported R6 complained on 10/10 pain left hip with externally rotated ankle. LPN II reported CNA EE remained with R6 on floor until EMR arrived after about 20 minutes. LPN II reported R6 transfer status prior to fall was staff assist of 1 with use of gait belt and walker and verified gait belt was no in place. During an interview on 12/10/24 at 12:30 PM, DON B reported would expect staff to use gait belt with all resident transfers and follow care plans. DON B reported R6 had history of refusing gait belt. DON B reported staff was re-educated on use of gait belt with resident transfers. Review of the provided education reflected staff sign in with no topic of education or date. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility, Transfer with a Gait Belt policy, undated, reflected, The resident will be assessed by professional therapies for the safest transfer option to provide the resident and staff with the utmost safety . Put on the resident's stockings/socks, shoes and gait belt .Face the resident .Grasp the gait belt on each side of the waist-with your fingers inserted up through eh bottom of the belt. Flex your knees and hips deeply, supporting the resident's knees with yours. Straighten your knees and hips, lifting the resident to a standing position at the same time. Pivot the resident so that the back of their legs are close to the chair, your hands still in position in the gait belt. Tell the resident that the chair is behind them and that you are going to lower them into the chair seat .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on interview and record review the facility failed to ensure catheter care/perineal care was provided for one (#124) of three reviewed for urinary catheters. Findings include: Review of the medical record revealed R124 admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/1/24 revealed R124 scored 3 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Additionally, R124's MDS indicated that he had a urinary catheter. R124 no longer resided in the facility. Review of a General Nursing Note dated 6/13/2024 7:09 PM revealed CNA [certified nursing assistant] states resident is c/o [complaining of] of burning to peri [perineal] area and penis at this time. Resident has indwelling catheter. Straw yellow urine draining from tubing and into bag with small amount of sediment. insertion site inspected and noted to have large amount of purulent drainage. Penis also reddened and slightly swollen. Review of a General Nursing Note dated 6/21/2024 4:47 PM revealed [resident family member] requests resident be sent to [local emergency department] for eval [evaluation] and tx [treatment] of uncontrolled pain from foley catheter, difficulty swallowing and penile discharge. Review of the Hospital Paperwork dated 6/21/24 revealed R124 the nurses at the hospital pulled back the foreskin and observed yeast and redness on R124's penis. R124 was discharged back from the hospital with an antifungal cream. Review of a secure conversation dated 6/22/24 revealed a request for the Physician to assess R124's foreskin. Additionally, the message stated Staff reminded of importance of pulling foreskin back when doing care and applying ointment. Review of a Urology consultation dated 7/5/24 revealed instructions to provide BID twice a day cleaning to penis. Review of the Care Plan revealed no instructions for ensuring catheter care was completed. Review of the Physician Orders revealed no instructions for ensuring catheter care was completed. Reveal of the Kardex revealed no instruction for ensuring catheter care was completed. Review of the Task section on the electronic medical record revealed no instructions for ensuring catheter care was completed. Review of the Medical Record revealed no documentation that catheter care was consistently being completed on R124. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 3:10 PM, Registered Nurse V confirmed the absence of catheter care orders and the absence of any catheter care being performed on R124.