STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235206	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Whitehall	916 E Lewis St Whitehall, MI 49461

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to provide for the needs of four of four residents (Resident #45, Resident #67, Resident #62, and Resident #7) reviewed for accommodation of needs. Findings: Residents #45 (R45) Review of an Admission Record revealed R45 was a [AGE] year old male, last admitted to the facility on [DATE], with pertinent diagnoses of Alzheimer's, lack of coordination, muscle wasting, and a below the knee amputation of the left leg. During an observation on 12/08/24 at 8:44 AM, R45's call light laid on the floor on the resident's left side of the bed, out of sight and out of reach. The same observations were made on 12/08/24 at 9:47 AM and 10:34 AM. During an observation on 12/08/24 at 11:47 AM, two staff entered R45's room and boosted him up in bed. During an observation on 12/08/24 at 11:55 AM, R45's call light hung down from the railing on the left side of the bed, just off the floor, out of sight and out of reach. During an observation on 12/08/24 at 3:19 PM, R45 stated that he was cold and he could not reach the blanket at the foot of the bed. When asked if R45 could locate the call light, R45 stated he could not. It remained hanging off the left side of the bed, almost touching the floor, out of sight and out of reach. During an observation on 12/08/24 at 4:28 PM, R45 laid in bed resting with his eyes closed and the call light hung off the left side of the bed, out of sight and out of reach. Certified Nurse Aide (CNA) Y looked into R45's room and asked how R45 was doing. When R45 did not answer, CNA Y did not go into the room and stated that R45 must be sleeping. Resident #67 (R67) (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R67 was a [AGE] year old female, originally admitted to the facility on [DATE], with pertinent diagnoses of vascular dementia, unsteadiness on feet, hard of hearing, and glaucoma. R67 required 1 assist from staff to ambulate, transfer, and use the bathroom. During an observation on 12/09/24 at 7:40 AM, R67's call light was activated. Staff entered the room and turned off the call light at 7:52 AM, spoke with the resident and then left the room. During an observation and interview on 12/09/24 at 7:55 AM, R67 sat in a wheelchair and was visibly shivering. R67 stated I'm so cold and that she had asked staff for help to get dressed but was told that staff was busy and she would have to wait until after breakfast to get dressed. Resident #62 (R62) Review of an Admission Record revealed R62 was an [AGE] year old female, originally admitted to the facility on [DATE], with pertinent diagnoses of dementia, abnormal weight loss, difficulty speaking, and high blood pressure. During an observation on 12/08/24 at 10:00 AM, R62 sat in a wheelchair at the nurses station and did not have any fluids available within reach for her to drink or for staff to offer. During an observation on 12/08/24 at 10:30 AM, R62 sat in a wheelchair at the nurses station and did not have any fluids available within reach for her to drink or for staff to offer. During an observation on 12/08/24 at 11:02 AM, R62 sat in a wheelchair at the nurses station and did not have any fluids available within reach for her to drink or for staff to offer. During an observation on 12/08/24 at 1:18 PM, R62 had been self propelling in her wheelchair throughout the halls since after lunch with no fluids available within reach. During an observation on 12/08/24 at 2:17 PM, R62 continued to self propel in her wheelchair throughout the halls without fluids available to her. During an interview on 12/08/24 at 3:56 PM, R62 stated I'm so thirsty. During an observation on 12/09/24 at 10:04 AM, R62 sat in a wheelchair at the nurses station with no fluids available to her. During an observation on 12/09/24 at 11:41 AM, R62 sat in a wheelchair at the nurses station with no fluids available to her. Resident #7 (R7) Review of an Admission Record revealed R7 was a [AGE] year old male, last admitted to the facility on [DATE], with pertinent diagnoses of chronic kidney disease, congestive heart failure, rheumatoid arthritis, muscle weakness, high blood pressure, and Hodgkin lymphoma. R7 was dependent on staff for transfers, bed mobility, and bathing. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/09/24 R7's call light was activated at 10:21 AM. The call light remained active at 11:46 AM and R7 stated that he was calling for staff so that he could get some fresh water. An empty water cup sat on the over-bed table and was labeled 3rd (shift) 12/8. Review of the facility policy Call Light revealed .Be sure call lights are placed within reach of residents who are able to use it at all times.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00147849 and MI00148347. Based on interview and record review, the facility failed to protect the residents' right to be free from verbal and mental abuse by staff for 5 of 24 residents (R8, R12, R35, R53, and R68), resulting in residents being verbally abused. Findings include: A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed verbal abuse includes but not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Examples: name calling, swearing . A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed mental abuse includes but is not limited to humiliation . Examples: statements such as . Take a shower, you stink . attempts to embarrass or tell on the resident . A review of the facility investigation report received by the State Survey Agency (SSA), dated 11/19/24, revealed it was reported to Interim Nursing Home Administrator (NHA) A at 11:50 am on 11/12/2024 by Certified Nursing Assistant (CNA) C that on 11/11/24 CNA B called R35 an a**hole while providing care and was rude, disrespectful, and used inappropriate language to R12. In addition, the facility investigation report also mentioned R53 as a resident who was also included in the investigation, but did not indicate the reason. R12 A review of R12's Admission Record, dated 12/10/24, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R12's Admission Record revealed multiple diagnoses that included depression. A review of R12's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 10/16/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed R12 was cognitively intact. A review of R12's Social Services note, dated 11/12/24, revealed, This writer along with the administrator met with this resident in regards to a reported incident that had occurred . A review of R12's typed and undated interview located in the facility's investigative file for the incident on 11/11/24 revealed, NHA A followed up with R12 regarding CNA C's allegation that CNA B was degrading towards him. R12 stated he did not know about the incident on 11/11/24 and had no issues with care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA C's typed interview, dated 11/14/24, revealed, CNA C reported to NHA A that on 11/11/24 CNA B had called R12 fat and disgusting while she was providing care to him. CNA C indicated that CNA B knew that R12 was hard of hearing and may not have heard her call him fat and disgusting. A review of CNA I's typed interview, dated 11/15/24, revealed when she came to work on 11/14/24 she noticed that R12's call light was on. She stated that she overheard CNA B inform CNA C that she was going to leave R12 on the toilet for five minutes while she completed another task. CNA I stated that when she heard this she proceeded to go assist R12 in the bathroom. CNA I stated CNA B informed her that she (CNA B) would help R12 immediately. CNA I stated she believed that CNA B was going to leave R12 on the toilet and not assist him. R35 A review of R35's Admission Record, dated 12/10/24, revealed they were an [AGE] year-old resident admitted to the facility on [DATE]. R35's Admission Record also revealed multiple diagnoses that included generalized muscle weakness, post-traumatic stress disorder (PTSD), unsteadiness on feet, and syncope (fainting) and collapse. A review of R35's MDS, dated [DATE], revealed a BIMS score of 12 which revealed R12 was moderately cognitively intact. A review of R35's Social Services note, dated 11/12/24, revealed, This writer along with the administrator met with resident to discuss a incident that took place yesterday, resident had no recollection of the incident . A review of R35's Employee to Resident Incident Report, dated 11/14/24, revealed CNA C reported to NHA A that CNA B called R35 an a**hole while she was in the room providing care (date not specified if other than 11/14/24). CNA C also stated CNA B called other residents *ssholes (date(s) not specified if other than 11/14/24). During an interview on 12/08/24 at 08:49 AM, R35 stated about a month or two ago an aide was sitting in his room doing paperwork. He stated he asked her to change his brief because it was wet and soiled. He stated the aide told him to shut up and then left the room. He stated she was with another aide and I guess she reported her because I had the social worker, administrator, and a bunch of other people interviewing me about it. He stated the facility investigated the issue and he has not seen the aide since. A review of CNA B's typed interview, dated 11/15/24, revealed CNA B denied that she called R35 an *sshole and stated she would never speak to residents that way. A review of CNA H's typed interview, dated 11/14/24, revealed CNA H stated CNA B often used profanity around residents. A review of CNA N's typed interview, dated 11/14/24, revealed she did not often work closely with CNA B. However, CNA N stated CNA B did use profanity at work. CNA N further stated that CNA B used the words sh*t and f*ck and that it was possible that CNA B used that language in patient care areas. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA O's typed statement, dated 11/14/24, revealed that she had heard CNA B use profanity around residents, but had never heard her swear at a resident. CNA O further stated CNA B had no filter (tended to say exactly what she thought without considering the consequences). CNA O also indicated that she takes pride in working at the facility and that CNA B's words made her feel uncomfortable. A review of Social Services Coordinator (SSC) E's typed interview, dated 11/14/24, revealed, that while SSC E was talking to R35 about the allegations of being a victim of verbal abuse by CNA B R35 did confirm that he heard CNA B swear but did not recall any words that were directed towards him. A review of Licensed Practical Nurse (LPN) P's typed interview, dated 11/14/24, revealed CNA B often used profanity in the workplace and had to be reminded to watch her language. A review of CNA Q's typed interview, dated 11/14/24, revealed, CNA B had used profanity towards residents in a joking manner. CNA Q stated CNA B's behavior was unprofessional and that sometimes it was difficult to tell whether she was joking or serious. A review of LPN R's typed interview, dated 11/14/24, revealed CNA B was very outspoken and blunt. LPN R stated he knew CNA B used profanity often but had never witnessed her using profanity around the residents. However, LPN R did state that CNA B did sometimes use profanity at the front desk. A review of CNA I's typed interview, dated 11/15/24, revealed CNA B used a lot of profanity at work. CNA I stated she had never heard CNA B swear at a resident. R53 A review of R53's Admission Record, dated 12/10/24, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R53's Admission Record revealed multiple diagnoses that included gangrene (dead tissue caused by an infection of lack of blood flow which can cause pus and foul-smelling discharge), generalized muscle weakness, and paranoid schizophrenia. A review of R53's MDS, dated [DATE], revealed a BIMS score of 15 which revealed R53 was cognitively intact. A review of R53's Social Services note, dated 11/12/24, revealed, This writer along with the administrator met with resident to discuss an issue that had been reported. He stated that the only complaint he had was when he has his call light on, it takes 40 minutes to an hour for a response. No further concerns . A review of R53's Employee to Resident Incident Report, dated 11/11/24, revealed that it was reported to NHA A that CNA B made derogatory statements to R53 regarding his hygiene. During an interview on 12/08/24 at 11:10 AM, R53 denied anyone had used inappropriate/derogatory language toward him. A review of R53's undated typed interview revealed NHA A spoke with R53. R53 indicated that he had no issues with CNA B and did not recall her making derogatory comments to him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA C's typed statement, dated 11/12/24, revealed, CNA C stated R53 was just waking up when they (CNA B and CNA C) went into the room to perform care. CNA C stated that while CNA B was in the room, she verbalized loudly that R53's room always smells like urine, that he has poor hygiene, and that he is just gross in general. CNA C stated that she believed R53 was sleeping and may not have heard CNA B make the statement. A review of SSC E's typed statement, dated 11/14/24, revealed, that when he interviewed R53 about the allegations against CNA B R53 denied knowing anything about the incident. A review of NHA A's typed statement, dated 11/15/24, revealed I spoke with [name of CNA B] regarding a report that I received about her degrading regarding [name of R53]'s hygiene. [Name of CNA B] indicated that the allegation was not true. I informed [name of CNA B] that it was reported that she informed a new hire of this while she was training them. She began to get upset and defensive. I informed [name of CNA B] of the importance of professionalism and that we must be mindful of what we say at work . A review of CNA O's typed statement, dated 11/14/24, revealed she felt that CNA B had no filter (tended to say exactly what she thought without considering the consequences). CNA O also indicated that she takes pride in working at the facility and that CNA B's words (or statements) made her feel uncomfortable. A review of CNA Q's typed interview, dated 11/14/24, revealed, CNA B's behavior was unprofessional and that sometimes it was difficult to tell whether she was joking or serious. A review of the facility's investigative documentation for the incident on 11/11/24, undated, revealed the following they concluded the following: - The facility verified, based on witness statements, CNA B did use profanity at work, including in resident care areas and around residents, and creates an uncomfortable work environment. - The facility verified that based on witness account, CNA B called R35 an *sshole and was degrading as it pertains to R12's and R53's hygiene. During an interview on 12/09/24 at 03:15 PM, the NHA stated all the allegations that CNA B had used degrading/derogatory language toward R12 and R53 and had called R35 an *sshole were substantiated. The NHA further stated she could not believe that they all occurred, but they did. She also stated she was shocked when she heard about them initially. A review of CNA B's Disciplinary Action Record Work Rules form, dated 11/18/24, revealed it was reported to NHA A that on 11/11/24 CNA B called residents *ssholes and was degrading to residents due to their hygiene. In addition, CNA B had a prior history of degrading residents and using profanity. CNA B s Disciplinary Action Record Work Rules form further revealed they were terminated from their employment at the facility effective 11/18/24. A review of CNA B's Employee Termination Form, dated 11/18/24, revealed CNA B was terminated from employment at the facility for calling residents names.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation is related to intake # MI00148049 Based on interview and record review, the facility failed to prevent the misappropriation of controlled substances for three (Resident #35, Resident #5, and Resident #174) of three residents reviewed. Findings: Resident#35 (R35) Review of an Admission Record revealed R35 was an [AGE] year old male, last admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus, post traumatic stress disorder, chronic obstructive pulmonary disease, and left lower extremity below the knee amputation. Resident #5 (R5) Review of an Admission Record revealed R5 was an [AGE] year old female, last admitted to the facility with pertinent diagnoses of dementia, anxiety disorder, claustrophobia, and chronic obstructive pulmonary disease. Resident #174 (R174) Review of an Admission Record revealed R174 was a [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of rheumatoid arthritis, chronic pain, and diabetes mellitus. Review of an Incident Report dated 10/31/24 reflected the following information: (a) the night of 10/30/24 at approximately 11:45 PM, certified nurse aide (CNA) CC observed Registered Nurse DD place a pill (later discovered to be the narcotic Oxycodone) prescribed to R35 in her pocket, (b) CNA CC asked R35 if he had received his pain medications and R35 stated he had not, (c) CNA CC then advised Unit Manager (UM) EE of the observation, (d) UM EE called Interim Nursing Home Administrator (I-NHA) A and reported the incident, (e) I-NHA A did not immediately report the incident to the State Agency and did not immediately suspend RN DD pending an investigation, (f) RN DD had picked up an additional over time shift and was still at the facility working when I-NHA A arrived to the facility at 7:30 AM on 10/31/24, (g) RN DD was then removed from the floor, (h) the Director of Nursing and Licensed Practical Nurse (LPN) P completed an audit of the medication cart RN DD had been using and discovered two additional narcotics were unaccounted for, (i) further investigation revealed that the two missing narcotics belonged to R5 and R174, and (j) the two missing narcotics prescribed to R5 and R174 were located in a medication cup in the bathroom of room [ROOM NUMBER]. During an interview on 12/10/24 at 12:30 PM, the current Administrator and the Regional Director of Clinical Operations X reviewed the details of the incident. There was no additional information provided beyond what had previously been stated in the initial report. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility submitted a packet of information requesting that past non-compliance be considered. However, the facility failed to show substantial compliance with narcotic documentation and storage at the time of the survey and remained out of compliance with professional standards of practice for controlled drug administration and documentation. Review of the facility policy Abuse and Neglect reflected: It is the policy of this facility to provide professional care and services in an environment that is free from .misappropriation of property.

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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. 30120 This citation refers to MI00147849 and MI00148347. Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act and report within a timely manner to facility management and the State Survey Agency allegations of verbal and/or mental abuse by staff for three of 24 residents (R12, R35, and R53), resulting in a delay in investigating allegations of abuse and the potential for residents to not be protected from abusive individuals Findings include: A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed verbal abuse includes but not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Examples: name calling, swearing . A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed mental abuse includes but is not limited to humiliation . Examples: statements such as . Take a shower, you stink . attempts to embarrass or tell on the resident . A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed, All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to the appropriate State Agencies (e.g. State Survey Agency) immediately after the initial report is received . The Administrator is the Abuse Coordinator . The abuse coordinator must submit a preliminary investigation report to the appropriate State agencies immediately once assurances for the resident's or other resident's safety have been established . A review of the facility investigation report received by the State Survey Agency (SSA), dated 11/19/24, revealed it was reported to Interim Nursing Home Administrator (NHA) A at 11:50 a.m. on 11/12/2024 by Certified Nursing Assistant (CNA) C that on 11/11/24 CNA B called R35 an *sshole while providing care and was rude, disrespectful, and used inappropriate language to R12. In addition, the facility investigation report also mentioned R53 as a resident who was also included in the investigation, but did not indicate the reason. The facility investigation report further revealed the incident was not reported to the State Survey Agency until 11/12/24 at 1:40 p.m. During a review of CNA C's personnel file on 12/10/24 at 9:35 a.m., Human Capital Partner (HCP) Z stated she was not aware if CNA C had received any education and/or discipline regarding her failure to report allegations of abuse in a timely manner to facility management when it was discovered that CNA C's personnel file did not have any educational opportunities or disciplines in it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 10:46 AM, the Nursing Home Administrator (NHA) stated CNA C had received a Teachable Moment for failing to report allegations of abuse timely to the interim Nursing Home Administrator (NHA A). A review of CNA C's Teachable Moment form, dated 11/12/24, revealed she had failed to report an allegation of abuse to the administrator immediately on 11/11/24. CNA C was educated that she needed to report all allegations of abuse to the NHA upon discovery.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to 1.) administer controlled medications following professional standards of practice, 2.) ensure medications were administered following the physician ordered parameters, and 3.) accurately transcribe/order a newly admitted resident's antipsychotic medication, for six of 12 residents (Resident #5, #46, #7, #2, #24, and #68) reviewed for medication administration, resulting in missed doses of medication, medication administration errors, and the inaccurate documentation of the administration of controlled drugs. Findings: Resident #5 (R5) Review of an Admission Record revealed R5 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. Review of R5's Order Summary revealed, HYDROcodone-Acetaminophen (Norco) Tablet 10-325 MG Give 1 tablet by mouth every 4 hours as needed for breakthrough pain management. Review of R5's Control Substance Record revealed that on 12/7/24 R5 received 4 doses of Norco. A dose was administered at 1:40 AM, an illegible time, at 5:38 PM and at 10:30 PM. Review of R5's December Medication Administration Record revealed the illegible dose was not documented as administered. Resident #46 (R46) Review of an Admission Record revealed R46 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. Review of R46's Order Summary revealed, HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth three times a day for pain related to CONTRACTURE, LEFT SHOULDER; CONTRACTURE, LEFT HAND; PAIN IN LEFT LEG. Review of R46's Control Substance Record revealed that on 12/7/24 only 2 doses of Norco were administered (at 9:00 AM and at 9:00 PM). Review of R46's December Medication Administration Record revealed all 3 doses of Norco were documented as administered on 12/7/24. Resident #7 (R7) Review of an Admission Record revealed R7 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: arthritis and pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R7's Order Summary revealed, oxyCODONE HCl Oral Capsule 5 MG (Oxycodone HCl) Give 1 tablet by mouth four times a day for pain. Review of R7's Control Substance Record revealed that on 12/4/24 only 3 doses of oxycodone were administered at (12:00 AM, 5:00 AM, and 12:00 PM). Review of R7's December Medication Administration Record revealed all 4 doses of oxycodone were documented as administered on 12/4/24. Resident #2 (R2) Review of an Admission Record revealed R2 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: heart disease. Review of R2's Order Summary revealed, Midodrine HCl Oral Tablet 5 MG Give 1 tablet by mouth three times a day for HYPO tension (low blood pressure) Hold for BP (blood pressure) OVER 120. To be administered at 9:00 AM, 3:00 PM, and 10:00 PM. Review of R2's December Medication Administration Record and Blood Pressure Summary revealed: *On 12/5/24 at 3:30 PM, R2's blood pressure was 125/59 and the 3:00 PM Midodrine was administered. R2's 10:00 PM dose of midodrine was administered without a blood pressure assessment. *On 12/6/24 at 8:47 PM, R2's blood pressure was 123/68 and the 10:00 dose of midodrine was administered. *On 12/7/24 R2's midodrine was administered at 9:00 AM and 3:00 PM without a blood pressure assessment. At 9:19 PM R2's blood pressure was 126/70 and his 10:00 PM dose of midodrine was administered. Resident #24 (R24) Review of an Admission Record revealed R24 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes type II. Review of R24's Order Summary revealed, Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 15 unit subcutaneously before meals for DM (diabetes mellitus) 15 units 3 times a day with meals hold if <120 (less than 120) or if not eating. Review of R24's Blood Sugar Log and November Medication Administration Record revealed: *On 11/6/24 R24's blood sugar was 91 at 6:00 AM and his 8:00 AM dose of insulin was administered. *On 11/20/24 R24's blood sugar was 97 at 6:00 AM and his 8:00 AM dose of insulin was administered. During an interview on 12/09/24 at 08:10 AM, Licensed Practical Nurse (LPN) U reported that narcotics were to be signed out of the narcotic book at the time the medication was removed from packaging and signed out of the Medication Administration Record following the administration of the narcotic. LPN U reported medications were to be administered following the physician ordered parameters. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Medication Administration last updated 12/19/19 revealed, POLICY: It is the policy of this facility that medications shall be administered as prescribed by the attending physician .2. Medications must be administered in accordance with the written orders of the ordering/prescribing physician .3. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR) .9. The nurse administering the medication must record such information on the resident's MAR before administering the next resident's medication . Review of the facility policy Medication Administration-Controlled Medications dated 7/11/18 revealed, .6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: o Date and time of administration. o Amount administered. o Signature of the nurse administering the dose, completed after the medication is actually administered . 37577 Resident #68 (R68) Review of an Admission Record revealed R68 was a [AGE] year old female, admitted to the facility on [DATE] following a hospitalization for increasing weakness and confusion at home. R68 was admitted to the facility with pertinent diagnoses of metabolic encephalopathy and bipolar disorder. Review of a hospital history and physical for R68, dated 08/29/24, revealed concerns for polypharmacy (taking too many medications), and was evaluated for improvement when several of her previously prescribed medications were held. Review of a hospital after visit summary dated 09/01/24, revealed an new reduced order for R68 to take 100 mg (milligrams) of quetiapine (an antipsychotic also known as Seroquel) at bedtime. Review of a Social Services progress note dated 09/03/24 reflected that R68 was taking 200 mg of quetiapine (Seroquel) at bedtime. Review of Electronic Medication Administration Records (Emar's) for R68, dated 09/01/24 through 12/09/24, revealed that R68 had received 200 mg of quetiapine at bedtime since her admission. (This reflects R68 received twice the ordered dose). During an interview on 12/10/24 at 1:45 PM, the Administrator, after reviewing the above information, indicated that yes R68 had been given an incorrect double dose of quetiapine.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to provide quality care to three of three residents reviewed (Resident #14, Resident #3, and Resident #19) resulting in untreated significant swelling in the feet for R14, an order to change tube feed guidelines for R3 to be missed, and a delay in treating a urinary tract infection for R19. Findings: Resident #41 (R41) Review of an Admission Record revealed R41 was a [AGE] year old male, originally admitted to the facility on [DATE], with pertinent diagnoses of seizure disorder, lymphedema, chronic kidney disease During an observation and interview on 12/09/24 at 4:30 PM, R41 laid in bed with eyes open and stated that his feet hurt. It feels like my feet are in gloves and the gloves keep getting smaller. R41 rated the pain in his left foot as really bad and reported intense pain if the foot was touched. R41 stated that he saw a lymphedema specialist in the past but has not seen the specialist since his admission to the facility. R41 had +4 edema to both feet, the skin on both feet was shiny and taut. Review of a Skin Observation Tool dated 12/07/24 and 12/08/24 reflected R41 had no new alteration in his skin integrity and that the appearance of his skin was normal. Review of a weight summary revealed R41 had a 16.9 pound weight increase between 11/25/24 and 12/04/24. Review of a Care Plan for R41 revealed the following: FOCUS: resident has potential/actual impairment to skin integrity . INTERVENTIONS: observe skin daily with cares. Report any changes in coloration, integrity, etc to the nurse .start date-09/20/23. Review of a Physician Assessment for R41 dated 11/13/24 showed that R41 had +2 bilateral lower extremity (BLE) edema. Review of a Progress Note by Physician Assistant (PA) BB dated 11/27/24 revealed that the +2 BLE edema noted on 11/13/24 was not re-assessed nor addressed. Review of a Progress Note by Physician Assistant (PA) BB dated 12/02/24 revealed that the +2 BLE edema noted on 11/13/24 was not re-assessed nor addressed. During an interview on 12/10/24 at 10:04 AM, the Administrator and Director of Nursing reported that there was no documentation to show that R41's significant increase in edema in his feet had been documented, monitored, or assessed. 37872 Resident #3 (R3) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R3 admitted to the facility on [DATE] with diagnosis of (but not limited to) Multiple sclerosis, dementia, dysphagia, delusional disorders, and chronic respiratory failure. Brief Interview for Mental Status (BIMS) reflected a score of 10 out of 15 which represented R3 was mildly impaired, however, she is no longer her own responsible party. Observation on 12/09/24 at 8:29 AM, R3 was sleeping, the head of the bed elevated. R3's tube feed was running, and the bottle of Jevity was dated/labeled 12/08/24 at 40ML (milliliters) every hour until 800 ML infused. The flush bag was dated 12/08/24 was being infused at 40 ML an hour. Review of R'3 medical record revealed the following progress note date 11/12/24 at 14:59 . Nurse request to evaluate tube feeding due to frequent clogging. (Using G-port to feed) Resident is receiving Jevity 1.5 @ 40 ml/hr X 20 hours or 800 ml infused + 40 ml flush Qhr during feeding time (800ml). Tube feedings are meeting current needs with goal of gradual wt. (weight) loss r/t high BMI (Body Mass Index) (27.4). Request to change feeds to higher rate and decrease volume which may help with frequent clogging. Request Jevity 1.5 @ 65ml/hr (milliliters per hour) x 13 hours or until 845ml infused. Increase flush to 60ml every hour during feeds .Continue to monitor weights and tolerance and adjust as needed. Flush with warm water to prevent clogging. If clogging continues maybe larger bore tube can be placed. Further review of R3's medical record reflected that no follow-up or changes were made to R3's tube feed orders between 11/13/24 to 12/08/24. During an interview on 12/09/24 at approximately 1:30 PM, NHA (Nursing Home Administrator) was asked if the Registered Dietitian's (RD's) recommendations for changing R3's tube feed orders had been reviewed/discussed from November. NHA stated she would look into it and get back with this surveyor. Review of R3's November 2024 Medication Administration Record (MAR) on 12/09/24 (after reviewing R3's progress notes) failed to reflect any change in the resident's Tube Feeding order. Review of R3's November MAR reflected she received the following tube feed order was for the month: Enteral feed Order at bedtime Cyclic Enteral Feeding: Formula: Jevity 1.5; Rate:40ml/hr; Start at 1900 time and run until 800 MLs has infused; Flush with water: Amount:40 ml q hour. Tube Type: PEG; Monitor Q Shift. Review of R3's December 2024 MAR on 12/09/24 and reflected R3 received the following order from 12/1 - 12/8/24. Enteral feed Order at bedtime Cyclic Enteral Feeding: Formula: Jevity 1.5; Rate:40ml/hr; Start at 1900 time and run until 800 MLs has infused; Flush with water: Amount:40 ml q hour. Tube Type: PEG; Monitor Q Shift. The order reflected a D/C Date of 12/09/24 at 16:52. Further review of R3's Enteral feed Order at bedtime Cyclic Enteral Feeding: Formula: Jevity 1.5; Rate:65ml/hr; Start at 1900 time and run until 800 MLs has infused; Flush with water: Amount:60 ml q hour. Tube Type: PEG; Monitor Q Shift. Start date on the tube feed order was 12/09/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 01:45 PM, NHA was asked if they had any information to provide about RD's November recommendation for (Name of R3). NHA stated, It (the recommendations) was never caught/followed up upon. It fell through the cracks, I was off on leave, we had an Interim NHA, we lost 2 DON's and now have an interim DON starting this week. We now have a new process where all recommendations will be CC'd to me, the acting DON, along w/ the Unit managers once they start. Resident #19 (R19) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE], revealed R19 had been readmitted to the facility on [DATE]. Further review of R19's Admission Record revealed multiple diagnoses that included Pneumonia due to Pseudomonas, Acute and Chronic Respiratory failure, Type 2 diabetes mellitus, and Chronic Obstructive Pulmonary Disease. A review of R19's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 11/21/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 14 which revealed R19 was cognitively intact. During the initial tour on 12/08/24 it was discovered that R19 was sent to the hospital over the weekend for a Urinary Tract Infection (UTI). Review of R19's general progress note dated 11/28/24 at 5:52 AM, reflected Resident alert and oriented. She has made her needs known and followed instructions. She is reporting that she feels as though she may have a bad UTI, due to legs feeling shaky. She reports that this was how it started the last time. She denied dysuria, freq. Did report some urgency. Her urine in toilet was noted to appear cloudy. Will contact provider with this. VSS, afebrile. She is observed to take in snacks and bedside fluids this shift. Review of general progress note dated 11/30/24 at 20:16, Review of urinalysis/lab, vital signs, and resident sx of low back pain, polyuria, dysuria, hematuria completed with (Name of NP). Orders to await culture prior to antibiotic therapy. Orders for AZO tablets to aid in resident's comfort were received and noted. Review of R19's Medication Administration Record (MAR) for December reflected she received 2 tablets in the morning of AZO Cranberry Oral Tablet 250-300 MG. From 12/1-12/5. On 12/6 it was documented that the resident had a Leave Absence (LA). Review of R19's general progress note dated 12/02/24 at 23:56 reflected Urine culture results are pending. Resident reports frequency of urine to be slightly pink. Cloudiness continues, no foul odor. Her vital signs are stable, she is afebrile.She reported back pain this HS and did receive a Norco with effective results. Ext. assist with transfer, and she did request use of w/c rather than walker due to her back causing her discomfort. Resident has been added to provider list for further eval. Review of general progress note dated 12/3/2024 at 23:55, reflected Resident reports to staff that she is not feeling well, but unable to explain what is wrong/hurting. vitals: 126/70, 94, 95% 2L NC, 18, 98.5, BS 122. Resident first states she is hot and sweaty, cool washrag applied to head/scalp; blankets removed. shortly after resident verbalized, she wanted to get up, resident assisted into WC and denies feeling hot states something is wrong she doesn't know what. denies needing PRN pain medication, pain 0. no abnormal findings during this time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of general progress note dated 12/4/2024 at 15:59, reflected Resident continues to be symptomatic of UTI. New orders obtained for ATB. Residents VSS. Resident stated she feels bad and does not want to therapy. Continues 2L via NC. Review of general progress note dated 12/05/2024 at 11:59, revealed Resident was administered her first dose of Macrobid 100 MG PO. Resident on medication BID x 7 days for UTI. VSS with a temp of 97.9. Alert with some confusion present, resident encouraged to drink more water and cranberry juice. Resident spends day in bed, denies wanting to get up. Review of general progress note dated 12/05/2024 at 13:37, revealed Resident had been experiencing increased confusion as the day progresses, VSS, cold sweats, Alert, but unable to answer questions correctly, resident has a good appetite, DON assessed and informed this nurse to send to ER. Review of R19's Medication Administration Report for December, reflected that R19 received one dose at breakfast on 12/05/24 of Macrobid Oral Capsule 100 MG (nitrofurantoin Monohyd Macro) Give 1 capsule by mouth two times a day for UTI for 7 Days. Review of R19's hospital progress notes revealed that on 12/05/24 resident was admitted to the hospital for UTI and lethargy, and she was being treated with Macrobid for known UTI. Report further revealed she was placed on a BiPAP and IV antibiotics. Resident remained hospitalized during the survey process. During an interview on 12/09/24 at 03:41 PM, NHA stated Resident was coming back sometime today. NHA further stated she would look into why it took so long for the resident to be put on any medication. During an interview on 12/10/24 at 01:50 PM, NHA stated that it was a long time between the Residents onset of symptoms the lab took a long time to get back with us, and we have filed a complaint and asked for an investigation into it. Resident is supposed to be coming back soon. It was a long time between onset and resident getting her first dose of an antibiotic.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation and record review, the facility failed to utilize foot rests on a wheelchair for two of four residents (Resident #44 and Resident #62) reviewed for accidents and hazards. Findings: Resident #44(R44) Review of an Admission Record revealed R44 was a [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of left sided paralysis following a stroke and abnormal posture. R44 requires assistance from staff for bed mobility, transfers, and using the bathroom. During an observation on 12/08/24 at 11:45 AM, Certified Nurse Aide (CNA) AA propelled R44 down the 300 hall to the nurses station without the use of foot rests on the wheel chair. Resident #62(R62) Review of an Admission Record revealed R62 was an [AGE] year old female, originally admitted to the facility on [DATE], with pertinent diagnoses of dementia, rheumatoid arthritis, and difficulty speaking. R62 is dependent on staff to get dressed, for bathing, transfers, going to the bathroom and can independently self propel in a wheelchair. Review of a Fall Risk Assessment for R62, dated 10/05/24, reflected that R62 was at high risk for falling partially due to overestimating and forgetting limits and a history of previous falls. During an observation on 12/08/24 at 9:54 AM CNA AA pushed R62 down the 300 hallway, in a wheelchair without ant foot rests on the chair. During an observation on 12/08/24 at 12:45 PM, R62 self propelled in a wheelchair down the 300 hall away from the dining area. Two meal service carts sat in the hallway side by side and R62 could not get around them. R62 leaned forward in the wheel chair and tried to push on the meal cart to move it out of her way. Staff did remove the meal cart from the middle of the 300 hall and R62 then self propelled the wheelchair into another resident seated in the hall way in her wheelchair. The wheel chairs became tangled together and both residents, visibly frustrated, tried to move the other wheel chair out of their way. Staff responded and untangled the wheel chairs after 5 minutes.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to ensure that pharmacy recommendations are received by the facility and reviewed by the physician for 1 of 5 residents (R53) reviewed for monthly pharmacy medication regimen reviews, resulting in the facility and physician not being aware of a pharmacy recommendation for R53 and the potential for an adverse outcome from medications and/or lack of assessment and monitoring of medications. Findings include: A review of the facility's Medication Regimen Review (MRR) Policy and Procedure, dated 7/11/18, revealed, It is the policy of this facility that: . 2. The pharmacist must report any irregularities to the attending physician, facility medical director and the Director of Nursing Services . the report is provided by the Pharmacist or facility to the responsible physicians and the Director of Nursing Services within seven (7) working days of review . A review of R53's Admission Record, dated 12/10/24, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R53's Admission Record revealed multiple diagnoses that included diabetes, hypertension (high blood pressure), hyperlipidemia (high lipid levels), paranoid schizophrenia. A review of R53's Medication Regimen Review form, dated 9/2/24, revealed the pharmacist checked the circle for See report for any noted irregularities and/or recommendations and did not note what the irregularities and/or recommendations were in the comments section of the form. A review of R53's electronic medical record, dated 9/2/24 to 12/10/24, failed to reveal the report from the pharmacist that coincided with the Medication Regimen Review form for 9/2/24 or any mention of what the irregularity and/or recommendations were that the pharmacist had referred to on the form. During an interview on 12/10/24 at 01:00 p.m., the Nursing Home Administrator (NHA) was made aware that the surveyor could not locate in R53's electronic medical record the pharmacy report for the irregularities and/or recommendations that were noted on R53's Medication Regimen Review form, dated 9/2/24, or any documentation in R53's medical record of what those irregularities and/or recommendations were. In addition, the surveyor notified the NHA that they could also not locate any documentation in R53's medical record that the physician was aware of any pharmacy recommendations or notices of irregularities with R53's medications. The NHA stated she would see if she could locate anything and if she did she would provide a copy to the surveyor. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview on 12/10/24 at 01:45 p.m., the NHA stated she had looked in R53's medical record, including progress and physician notes, and was unable to locate the pharmacy recommendation for 9/2/24 or evidence that the physician was aware of any recommendations. She stated, It doesn't look like we have it. But I have other people looking and if I find it I'll give it to you. A copy of any documentation that the facility could locate related to the 9/2/24 pharmacy recommendation was requested from the NHA. The NHA verbalized understanding. As of the completion of the survey and exit from the facility, the facility failed to provide any further documentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37872 Based on observation, interview, and record review, the facility failed to effectively clean and maintain food service equipment, and date mark potentially hazardous food item potentially affecting 68 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include: During the initial tour of the kitchen on 12/08/24 between 8:18 AM to 9:05 AM the following issues were observed and identified to [NAME] V: Observation of the Walk In Cooler (WIC) revealed mold, mildew, grime, and debris on the shelving. located inside the and on the fan compressor grate. An undated container storing hot dogs were being stored on the shelving. Observation of the cook line area revealed the can open blade and holster have food residue and debris on them. Further, observation of the cook line revealed the lid on the commercial blender had a yellow/white build-up of scale/lime with a touch of black speckles that resembled mold/mildew. An observation of the Walk In Freezer (WIF) revealed ice build-up on the shelving, and on the opened/sealed boxes of food located directly beneath compressor unit. Observation of the Reach In Cooler units located throughout the kitchen were observed to have food resident and debris in the following areas: shelving, bottoms, doors and door openings. During an interview on 12/09/24 at 7:44 AM, Dietary Manager (DM) W stated they had been working on the cleaning and findings from the initial tour of the kitchen. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NONFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking. (B) .refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME AND TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time of the original container is opened in a FOOD ESTABLISHMENT and if the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations .(1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as DAY 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by date based on FOOD safety. (continued on next page)

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Skld Whitehall	916 E Lewis St Whitehall, MI 49461

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-305.11 Food Storage, (A) . FOOD shall be protected from contamination by storing the FOOD: (1) In a Clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At lease 15cm (6 inches) above the floor. According to the 2017 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. According to the 2017 FDA Food Code section 4-602.13, NONFOOD CONTACT SURFACES. NONFOOD CONTACT SURFACES OF EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39056 Based on interview and record review, the facility failed to implement a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, and visitors to prevent the spread of an illness/outbreak. Findings: On 12/8/24 at 9:20 AM, a copy of the last 3 months of infection surveillance/tracking (all illnesses) for staff and residents including line lists were requested. During the onsite survey Previous Director of Nursing/Infection Control Preventionist (PDON/ICP) S abruptly ended her employment with the facility on 12/8/24 and was unable to be interviewed regarding the Infection Control Program. During an interview on 12/10/24 at 10:28 AM, Regional Director of Clinical (RDC) X reported PDON/ICP S had been responsible for the Infection Control Program for approximately the last 6 weeks. Prior to that PDON/ICP T had been responsible for the program. RDC X reported PDON/ICP S and T were responsible for the implantation, oversight, and maintenance of the Infection Control Program. Review of the Infection Control Program documentation for October-December 2024 revealed no surveillance/tracking/monitoring for infections for employees or residents. There were no line lists for confirmed or suspected infections for residents or for employees. Review of the 300/400 Unit Scheduling Book located at the nurses' station revealed the following Employee Absence Forms: On 12/6/24 a Certified Nursing Assistant (CNA) called off of work for she is sick On 12/7/24 a CNA called off of work for diarrhea, stomach pain On 12/7/24 a Licensed Practical Nurse (LPN) called off of work for fever, chills, sore throat There was no documentation that PDON/ICP S identified the unit the employees worked, the residents they came into contact with, the date they last worked, confirmed/suspected illness, or a date they could return to work in order to prevent the spread of infection to the vulnerable residents. Review of the facility policy Infection Prevention and Control-Surveillance dated 7/11/18 revealed, PURPOSE: To conduct surveillance of resident and employee infections to guide prevention activities. POLICY: The Infection Preventionist/designee does surveillance of infections among residents, employees, volunteers and visitors. I. The Infection Preventionist/designee does surveillance of healthcare-associated infections by: A. Review of culture reports and other pertinent lab data .G. Maintenance of the employee infection record H. Physician consultation .III. Surveillance documentation is maintained on the: A. Line Listing of the Monthly Infection Surveillance Log o Monthly Infection Surveillance Summary Report o Monthly Summary Infection Control Graph B. Log of Employee/Volunteer/Visitor Infections . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy Infection Prevention and Control dated 7/11/18 revealed, I. GOALS The goals of the infection prevention and control program are to: A. Decrease the risk of infections and communicable diseases to residents, employees, volunteers and visitors. B. Monitor for occurrence of infection and communicable diseases and implement appropriate prevention and control measures. C. Identify and correct problems relating to infection prevention and control practices. D. Maintain compliance with state and federal regulations relating to infection prevention and control. II. SCOPE OF THE INFECTION PREVENTION AND CONTROL PROGRAM The infection prevention and control program is comprehensive in that it addresses the prevention, identification, reporting, investigation and controlling of infections and communicable diseases among residents, employees, volunteers and visitors. The scope of services depends on the resident population, function, and specialized needs of the healthcare facility. THE MAJOR ACTIVITIES OF THE PROGRAM ARE: A. SURVEILLANCE OF INFECTIONS WITH IMPLEMENTATION OF CONTROL MEASURES AND PREVENTION OF INFECTIONS-There is on-going monitoring for infections among residents, employees, volunteers and visitors and subsequent documentation of infections that occur. Prevention of spread of infections is accomplished by use of hand hygiene, standard precaution, transmission based precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness .IV. REPORTING MECHANISMS FOR INFECTION PREVENTION AND CONTROL-A. Resident infection cases are monitored by the IP. The IP completes the line listing of infections and the monthly report forms and: 1. Reports to the Infection Prevention and Control Committee 2. Reports to the Infection Prevention supervisor and others as directed 3. Provides feedback to staff as needed. B. Employee infections and exposures to bloodborne pathogens or communicable diseases are reported by the employee to the employee's supervisor, then to the IP or Occupational Health Nurse (OHN) or designee. The IP/OHN/designee completes the employee infection report form and reports a summary to the: 1. Infection Prevention and Control Committee 2. Infection Prevention/Occupational Health Supervisor and others as directed .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to 1.) implement an antibiotic stewardship program and 2.) ensure accurate monitoring and antibiotic use for two of 5 residents (Resident #45 and #5) reviewed for antibiotic use, resulting in inappropriate antibiotic utilization and the potential for antibiotic resistance. Findings: During the onsite survey Previous Director of Nursing/Infection Control Preventionist (PDON/ICP) S abruptly ended her employment with the facility on 12/8/24 and was unable to be interviewed regarding the Infection Control Program. During an interview on 12/10/24 at 10:28 AM, Regional Director of Clinical (RDC) X reported PDON/ICP S had been responsible for the Infection Control Program for approximately the last 6 weeks. Prior to that PDON/ICP T had been responsible for the program. RDC X reported PDON/ICP S and T were responsible for the Antibiotic Stewardship Program which included monitoring the use of antibiotics and ensuring clinical criteria was met, appropriate antibiotics were ordered, with an appropriate indication for use. Resident #5 (R5) Review of an Admission Record revealed R5 was an [AGE] year-old female, admitted to the facility on [DATE]. Review of R5's Order Summary dated 10/22/24 revealed, Ciprofloxacin HCL Oral Tablet 500MG. Give 1 tablet by mouth two times a day for UTI (Urinary Tract Infection) for 5 days. Review of R5's Electronic Medical Record revealed no clinical criteria for the use of the antibiotic, no documentation that a culture and sensitivity report was reviewed to ensure the appropriate antibiotic was administered for R5's UTI, and no provider rationale for the continued use of the antibiotic without a culture result or clinical indication for use. During an interview via email on 12/10/24 at 8:34 PM, RDC X confirmed there was no documentation regarding the continued use of the antibiotic, a culture and sensitivity report result, or other relevant documentation. Resident #45 Review of an Admission Record revealed R45 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: neuropathic bladder. Review of R45's Order Summary dated 12/6/24 revealed, Macrobid Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 100 mg by mouth two times a day for UTI for 5 Days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R45's Progress Note dated 12/7/24 revealed, .Patient will begin cipro for tx (treatment) of UTI r/t C&S (related to culture and sensitivity) showing resistance to current abt. (antibiotic) . Confirming an ineffective antibiotic was started prior to the culture and sensitivity report. Review of R45's Order Summary dated 12/7/24 revealed, Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for UTI for 7 Days. Review of R45's Laboratory Report revealed R45's urine was collected for testing on 12/3/24, was received by the lab on 12/5/24, and reported on 12/6/24. The culture and sensitivity report indicated ciprofloxacin was an appropriate antibiotic to use for the bacteria identified in R45's urine. Macrobid was not listed as an effective antibiotic. Review of R35's December Medication Administration Record revealed Macrobid was administered once on 12/6/24 and once on 12/7/24 despite the culture and sensitivity report result on 12/6/24. Review of the Infection Control Program documentation for October-December 2024 revealed no surveillance/tracking of infections and/or antibiotic use or line listings of infections. Review of the facility policy Infection Prevention and Control-Surveillance dated 7/11/18 revealed, PURPOSE: To conduct surveillance of resident and employee infections to guide prevention activities. POLICY: The Infection Preventionist/designee does surveillance of infections among residents, employees, volunteers and visitors. I. The Infection Preventionist/designee does surveillance of healthcare-associated infections by: A. Review of culture reports and other pertinent lab data .G. Maintenance of the employee infection record H. Physician consultation . Review of the facility policy Infection Prevention and Control-Antibiotic Stewardship dated 7/11/18 revealed, POLICY: It is the policy of this facility that antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. PROCEDURE: 1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. 2. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community . 4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: Drug name; Dose; Frequency of administration; Duration of treatment; (1) Start and stop date, or (2) Number of days of therapy; Route of administration; and Indications for use. 5. When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. 6. Discharge or transfer medical records must include all of the above drug and dosing elements .8. When a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the following information available: Signs and symptoms; When symptoms were first observed; Resident's hydration status; Current medication list; Allergy information; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Infection type; Any orders for warfarin and results of last INR; Last creatinine clearance or serum creatinine, if available; and Time of the last antibiotic dose .10. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to provide the pneumococcal immunization per consent and the recommendation by the Centers for Disease Control and Prevention (CDC) for three (Resident #18, #4, and #56) out of 5 reviewed for immunizations, resulting in residents not receiving the pneumococcal immunization. Findings: Review of the CDC Pneumococcal Vaccine Timing for Adults dated October 2024 revealed, .the minimum interval for PPSV23 is >1 year since last PCV13 dose and >5 years since last PPSV23 dose. Shared clinical decision-making option for adults >[AGE] years old-Together, with the patient, vaccine providers may choose to administer PCV20 or PCV21 to adults >[AGE] years old who have already received PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old . Resident #18 (R18) Review of an Admission Record revealed R18 was an [AGE] year-old female, admitted to the facility on [DATE]. R18's Electronic Medical Record revealed that she was prescribed an antibiotic for a diagnosis of left lung base pneumonia on 10/3/24. Review of R18's EMR revealed no documentation that the pneumonia vaccine had been administered and/or discussed with the resident/guardian. There was no documentation that a consent and/or refusal for the immunization had been obtained since her admission to the facility. Resident #4 (R4) Review of an Admission Record revealed R4 was a [AGE] year-old female, originally admitted to the facility on [DATE] with the most recent admission (readmission) on 9/30/24. R4's Electronic Medical Record revealed that she was prescribed an antibiotic for a diagnosis of pneumonia on 11/18/24. Review of R4's EMR revealed no documentation that the pneumonia vaccine had been administered and/or discussed with the resident/guardian. There was no documentation that a consent and/or refusal for the immunization had been obtained following her readmission to the facility. Resident #56 (R56) Review of an Admission Record revealed R56 was an [AGE] year-old male, originally admitted to the facility on [DATE] with the most recent admission (readmission) on 10/14/24. R56 had pertinent diagnoses of lung and heart disease. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's Electronic Medical Record revealed that he was prescribed an antibiotic for a diagnosis of pneumonia on 8/9/24 and again in 12/6/24. Review of R4's EMR revealed no documentation that the pneumonia vaccine had been administered and/or discussed with the resident/guardian. There was no documentation that a consent and/or refusal for the immunization had been obtained following his admission and/or readmission to the facility. On 12/8/24 at 9:20 AM, a copy of resident covid, flu, and pneumonia vaccination status for with the date of administration as well as consent/refusal documentation was requested. During the onsite survey Previous Director of Nursing/Infection Control Preventionist (PDON/ICP) S abruptly ended her employment with the facility on 12/8/24 and was unable to be interviewed regarding the Infection Control Program. During an interview on 12/10/24 at 10:28 AM, Regional Director of Clinical (RDC) X reported PDON/ICP S had been responsible for the Infection Control Program for approximately the last 6 weeks. Prior to that PDON/ICP T had been responsible for the program. RDC X reported PDON/ICP S and T were responsible for ensuring influenza, pneumonia, and covid immunizations were offered as appropriate to all residents. During an interview via email on 12/10/2024 at 3:52 PM, RDC X confirmed there was no historical data that R56 had received the pneumococcal immunizations, and she would be obtaining a consent and offering the immunization. R4 had received the PPSV23 in 2011 and 2016 and the PCV13 in 2019 and she would be obtaining a consent and offering the immunization. R18 received the PPSV23 in 2005 and 2007 and the PCV13 in 2018 and would be obtaining a consent and offering the immunization. Review of the facility policy Infection Prevention and Control dated 7/11/18 revealed, THE MAJOR ACTIVITIES OF THE PROGRAM ARE: A. SURVEILLANCE OF INFECTIONS WITH IMPLEMENTATION OF CONTROL MEASURES AND PREVENTION OF INFECTIONS-There is on-going monitoring for infections among residents, employees, volunteers and visitors and subsequent documentation of infections that occur .Staff and resident education focuses on risk of infection and practices to decrease risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment. Immunizations are offered as appropriate to residents and employees to decrease the incidence of preventable infectious diseases .