STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Bloomfield Hills	2975 N Adams Road Bloomfield Hills, MI 48304

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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 0600 Level of Harm - Actual harm Residents Affected - Few	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** 32568 This citation pertains to Intake Number(s): MI00142885, MI00142866, MI00142560, and MI00142461. Based on observation, interview, and record review, the facility failed to protect three (R810, R808, and R809) residents' rights to be free from physical and verbal abuse by staff and residents. Findings include: A review of a complaint submitted to the State Agency revealed an allegation that a staff member (Certified Nursing Assistant - CNA 'E') slapped R810, it was observed by facility, and on camera. A review of a second complaint submitted to the State Agency revealed that R810 was assaulted by CNA 'E' while seated in a wheelchair. A review of a Facility Reported Incident (FRI) submitted to the State agency revealed it was reported that CNA 'E' physically abused R810 and it was witnessed by staff. On 5/7/24, an onsite investigation was initiated. On 5/7/24 at 12:28 PM, R810 was observed sleeping on her bed. R810 did not respond when name was called. A review of a police report dated 1/29/24 revealed they were dispatched to the facility on [DATE] at 3:23 PM for a report of assault. The police report documented, The caller stated that a worker at the facility assaulted a patient. The police report noted that the former Administrator of the facility (Administrator 'M') was interviewed by police. The following was documented, (Administrator 'M') advised that (Housekeeper 'F') . witnessed an assault today. (Housekeeper 'F') informed (Administrator 'M') that she saw an assault occur on the second floor in the hallway. (Administrator 'M') reviewed video footage and found the assault that (Housekeeper 'F') had witnessed . .The video shows (R810) sitting in her wheelchair in the hallway by herself. A care worker at the facility (CNA 'E') is seen walking from the bottom of the video screen towards (R810). As (CNA 'E') steps next to (R810's) wheelchair, (CNA 'E') attempts to grab (R810's) hand. (R810) flinches and recoils her hand backwards so that (CNA 'E') cannot grab it. (CNA 'E') then strikes (R810) in her mouth with her left hand. (CNA 'E's) hand was open when she struck (R810) . (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The police report included a summary of their interview with CNA 'E' which revealed CNA 'E' came to the police station with attorneys and the following was noted, .(CNA 'E') explained that there are some very combative patients at (facility name). (CNA 'E') said the resident listed as the victim in my report wasn't her patient and wasn't sure of her name .(CNA 'E') did know (R810) liked to wander and wasn't allowed out of her area because she was combative .Before the incident, (CNA 'E') said staff had told her (R810) couldn't be allowed on her floor/wing. Somehow, (CNA 'E') was alerted that (R810) was trying to leave her area. (CNA 'E') went to the back of (R810's) wheelchair to pull her away from door, but (R810) was too strong. Then (CNA 'E') tried to push the wheelchair, but (R810) started spitting. (CNA 'E') said (R810) spit on her hand and at her. (CNA 'E') described (R810) as 'carrying on.' Then (CNA 'E') demonstrated what appeared to be a swatting motion with her left hand. (CNA 'E') said her action was a knee-jerk reaction . .Summary between the video and (CNA 'E's) statement: (CNA 'E') stated that (R810) was 'carrying on' and was very strong. (CNA 'E') also stated she tried moving (R810) by pulling and pushing the wheelchair. The video showed that (CNA 'E') never tried pushing or pulling (R810's) wheelchair. (R810) smacks (CNA 'E's) hand when (CNA 'E') tries to grab her hand, but it doesn't do anything physically that is combative. I cannot tell if (R810) spit at (CNA 'E') when she is grabbing (R810's hand) .Status: Sent to (county prosecutor's office) to review for charges of Vulnerable Adult Abuse on (CNA 'E') . It was further documented in the police report that on 2/16/24, the county prosecutor issued Vulnerable Adult Abuse 4th Degree and Assault and Battery charges on CNA 'E'. On 2/29/24, CNA 'E' was arraigned at the court. A review of a Narrative Report written and signed by Housekeeper 'F' revealed, .I witnessed a nurse slap a elderly women <sic> in a wheelchair across her face. Onec <sic> the nurse notice I witnessed it she immediately ran over to me and started apologizing several times. I immediately walked over to the elderly patient and ask if she was ok. The patient shook her head no and started pointing at the nurse who slap her across her face . A review of the facility's investigation revealed a summary that documented Housekeeper 'F' reported on 1/29/24 that she witnessed CNA 'E' slap R810 in the face. It was noted that R810 could not be interviewed due to her cognitive status. The Administrator and Director of Nursing (DON) reviewed the video for that area and confirmed that the incident occurred. It was documented that abuse was substantiated. A review of a letter sent to CNA 'E' on 4/2/24 revealed the State Agency intended to revoke her nurse aide certificate due to the abuse allegation. A review of CNA 'E's personnel file revealed an Employee Termination Form dated 2/1/24 that documented, Reason for Termination .Abuse - Employee slapped a resident in the face . On 5/7/24 at 12:21 PM, a phone interview was attempted with Housekeeper 'F'. Housekeeper 'F' was not available for interview prior to the end of the survey. On 5/7/24 at approximately 10:00 AM, Human Resources (HR) Director 'A' reported CNA 'E's employment at the facility was terminated due to slapping a resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/7/24 at 12:40 PM, an interview was conducted with the current Administrator at the facility who is also the Abuse Coordinator. The Administrator did not work at the facility at the time of the physical abuse by CNA 'E' toward R810 and was not aware that is occurred. On 5/7/24 at 1:25 PM, a review of the video footage of the incident on 1/29/24 was conducted in the presence of the Administrator and the DON. In the video, CNA 'E' approached R810 who was seated in a wheelchair in the hallway. CNA 'E' attempted to grab R810's right hand and R810 swatted CNA 'E's hand away. Then CNA 'E' smacks R810 across the mouth using an open hand. A review of R810's clinical record revealed R810 was admitted into the facility on [DATE] with diagnoses that included: bipolar disorder, anxiety disorder, and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R810 had severely impaired cognition and exhibited physical and verbal behaviors and rejected care at times. 49083 R808 and R809 A review of a Facility Reported Incident (FRI) revealed an allegation of resident-to-resident physical abuse involving R808 (perpetrator) and R809 (victim) that occurred on 2/10/24 at 9:45 AM. On 5/8/24 a record review revealed R808 was admitted to the facility on [DATE] with diabetes, neuropathy (nerve damage affecting the hands and feet), heart disease, and chronic obstructive pulmonary disease (COPD). A Brief interview mental status (BIMS) score evaluated in February 2024 revealed a score of 15/15 indicating R808 was cognitively intact. Clinical record review of R809 revealed readmission to the facility on [DATE] with a diagnosis of diabetes, pancreatitis, bipolar, dementia, anxiety, dysphagia (difficulty swallowing), and a Percutaneous Endoscopic Gastrostomy (PEG) Tube (surgically placed tube into the stomach to deliver nutrition). A BIMS score evaluated in February 2024 revealed a score of 9/15 indicating R809 was moderately cognitively impaired. On 5/8/24 at 10:30 AM, R809 was interviewed and immediately referred to R808 as a hot head R809 recalled the event and stated he was in his wheelchair and R808 just came up and hit him in the back of the neck. R809 stated that it was a hard hit, did not result in any trauma, but it hurt at the time. R809 further stated that R808 announces R809 is not allowed in the activities room and tells him he is not welcome. On 5/8/24 at 10:40 AM, Licensed Practical Nurse (LPN) Q stated R809 frequently is hostile to other residents, swears, steals food from the delivery cart, from other residents' trays, and is not well liked by other residents. On 5/8/24 at 11:00 AM, R808 recalled the FRI and replied that he and R809 used to be roommates and never got along with each other. R808 stated they were separated and are on opposite ends of the building and that R809 frequently swears at other residents and is always stealing food off resident trays. R808 stated on the day of the incident, R809 was in his wheelchair blocking the pathway and R808 told him to move R808 responded fuck you at which time R809 acknowledged hitting R808 in the back of the head. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/8/24 at 2:51 PM, The Director of Nursing (DON) and Regional Nurse Consultant G indicated the statement made by LPN Q regarding R809 was new information, and the DON and G were unaware of the behaviors. The DON and G indicated the staff need to document such behaviors and will follow up with the staff. On 5/8/24 at 4:41 PM, An interview with staff witness to the incident Certified Nurse Assistant (CNA) R recalled walking towards the second-floor nutrition room and overheard R808 say move and R809 replied Fuck You CNA R walked towards the corner by the elevators and confirmed observation of R808 hitting R809 in the back of the head. A review of a facility policy titled, Abuse and Neglect, updated 3/24/23, revealed, in part, the following: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse .Abuse defined as the willful infliction of injury .intimidation or punishment with resulting physical harm, pain or mental anguish .Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00143743. Based on observation, interviews, and record reviews the facility failed to provide a written copy of the bed hold notification to the resident's representative, upon transfer to the hospital for one (R803) of four residents reviewed for transfers/discharges. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part, . Resident was transferred to the hospital on 3/15/2024. Guardian was not notified prior to hospital transfer nor was the bed hold policy provided . Family visited the resident's room on 4/1 (2024) and the resident's belongings have been removed from the room. Family was not given any notification prior to removing belongings or after . On 5/8/24 at approximately 2:30 PM, R803 was observed lying on their back in bed sleeping. R803 was observed to have a pink tie-dyed shirt with a green comforter covering their lower body. R803 did not open their eyes to verbal stimuli and continued to sleep. Review of the medical record revealed R803 was initially admitted to the facility on [DATE], a readmitted [DATE], with diagnoses that included: Chronic kidney disease (Stage 4), gastrostomy, epilepsy, and neuromuscular dysfunction of bladder. Review of the progress notes revealed on 3/15/24 at 9:39 AM, the Director of Nursing (DON) documented a change of condition note. Further review of the progress notes revealed the resident was sent to the hospital for decreased urine output coupled with an acute kidney injury. Review of the medical record revealed no documentation of the bed hold notice to have been provided to R803's representative. Review of a facility policy Bed Hold Policy (no date), documented in part . Facility must provide a copy of this policy to the resident and an immediate family member or legal representative before and when a resident is transferred for hospitalization . On 5/8/23 at 3:13 PM, the DON was interviewed and asked the facility's protocol on issuing residents who transfer out to the hospital the bed hold notice to the resident and/or resident representative and the DON stated the Admissions department would take care of that and notify the family and/or family representative of the facility's bed hold policy. When asked where the facility documents that a bed hold policy has been provided, the DON stated they would look into that and follow back up. The DON was then asked why R803's representative was not notified of the bed hold policy for their transfer to the hospital on 3/15/24, the DON replied that the Admissions personnel had just resigned, however would look into it, and follow back up. No further explanation or documentation was provided by the end of the survey.

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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** 34275 This citation pertains to Intake# MI00142366 Based on observation, interview and record review the facility failed to ensure resident's medications were stored securely, administered as ordered and documented according to professional nursing standards for five (R802, R804, R812, R813 and R816) out of sixteen residents reviewed for professional standards. Findings include: A Complaint was filed with the State Agency (SA) that alleged a resident did not receive their pain medication and was told by Staff that their pain medication had been given to other residents. R812 A review of R812's clinical record documented the resident was admitted to the facility on [DATE] with diagnoses that included: aftercare following joint replacement surgery. The resident initial assessment indicted the resident was cognitively intact. A review of the resident's Medication Administration Record (MAR) noted that that the following controlled substance/narcotic medications were administered on 1/18/24: Morphine Sulfate Extended Release 15 MG (milligrams) give 1 tablet by mouth every 12 hours for pain. Given on 1/18/24 at 9:00 AM (signed by Nurse H) and 9:00 PM (signed by Nurse I). Oxycodone 20 MG give 1 tablet by mouth every 12 hours for moderate to severe pain. Given on 1/18/24 at 9:00 AM (signed by Nurse H) and 9:00 PM (signed by Nurse I). On 5/8/24 at 10:55 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to whether R812 received their ordered pain medication as noted on the MAR. The DON reported that the medication had been ordered upon the resident's admission to the facility but had not yet arrived and the nurses needed to obtain the medication from their backup box. The DON further reported that they had determined that Nurse I did not provide the medication (Morphine and Oxycodone) to R812 on 1/18/24 at 9:00 PM as noted in the MAR. When asked if Nurse H provided the medication (Morphine 15 MG and Oxycodone 20 mg) at 9:00 AM as noted in the MAR, they replied that to their knowledge the resident did receive the medication. A request was made to provide documentation that the controlled substance medications were pulled from the backup box by Nurse H on 1/18/24 at 9:00 AM as noted in the MAR. The only document provided by the facility was a form titled, Transaction by Employee and Witness that noted Morphine 15MG was pulled by Nurse H and witnessed by Nurse J on 1/19/24 at 8:39 AM as it was noted that Nurse I never gave the medication. No documents were provided as requested for the date 1/18/24 by the end of the Survey. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview was conducted with Nurse I on 5/8/24 at approximately 2:55 PM. When asked about the medication that was noted as given in R812's MAR, Nurse I reported that they checked it was given in error as it was a very busy evening. It should be noted that Nurse I no longer works at the facility. A phone interview was conducted with Nurse H on 5/8/24 at approximately 2:49 PM. When asked if they recalled providing (Morphine 15 MG and Oxycodone 25 MG) to R812 on 1/18/24 and whether the medications were signed out and witnessed by nursing staff, they indicated that they recalled pulling the medication from the backup box but the resident refused the medication and left the facility. A follow-up interview with the DON was conducted on 5/8/24 at approximately 3:42 PM. The DON was again asked if they were able to locate documentation that the narcotics were removed from the back-up box as it was identified that Nurse H administered the medication. The DON was not able to locate any documentation to ensure the medication was pulled. R804 and R816 On 5/7/24 at approximately 9:27 AM, during an interview with R804, an enteral feeding bag dated 5/2/24 was observed hanging from a feeding tube pole near R816's bed. Next to the feeding tube pole was a bedside table. On the table were two boxes of prescription medication, Labetalol Hydrochloride injection (a beta-blocker that is used to control blood pressure in severe hypertension) and Mupirocin Ointment 2% (an antibiotic ointment). On the top of a chest of drawers in between R804 and R816's bed were two packages of generic cold and flu medications. R804 was asked about the medications located in their room. R804 reported that they had a roommate (R816) that went to the hospital about four days ago and could not verify if they took the medications on their own. As for the two packages of cold and flu medication, R804 stated that a family member brought them in for them to use when needed. On 5/7/24 at approximately 9:45 AM, Nurse J was queried as to the facility protocol pertaining to medications left unlocked in residents' rooms. Nurse J noted that medications should not be left in residents' rooms. Nurse J entered into R804 and R816's room and stated that R816 was sent to the hospital and was not sure why the medications remained in the room. As for the cold and flu medications, Nurse J again noted that they should not be in room. A review of R804's clinical record noted the resident was admitted to the facility on [DATE] with diagnoses that included pressure ulcers stage III and type II diabetes. The resident has been noted as having a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). There was no documentation in the resident's record for an order of cold and flu medication. Further there was no documentation that noted they could self-administer any medication. A review of R816's clinical record noted that the resident was initially admitted to the facility on [DATE] with diagnoses that include dementia and type II diabetes. The resident was discharged to the hospital on 5/3/24 as such documentation was limited. There was no documentation that noted the resident was able to self-administer medications. R802 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/7/24 at approximately 10:05 AM, R802 was observed lying in bed. The resident was alert and could answer some questions asked. The resident was observed to have red crusty areas on the left side of their face and in the left ear. On the bedside table was a box of Ketoconazole Cream (an antifungal medication) 2 %. When asked about the medication, the resident was not able to provide an answer as to how it is used. A review of R802's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: schizoaffective disorder, bipolar disorder and type II diabetes. The resident was noted to have a BIMS score of 15/15. There was an order dated 2/29/24 for Ketoconazole Cream 2% to be applied topically two times per day for candidiasis. Per the resident's MAR the medication was administered by nursing staff. There was no documentation in R802's record that noted the resident could self-administer the medication. On 5/7/24 at approximately 3:43 PM, Nurse N was asked why the Ketoconazole Cream 2% was left in R802's room and whether they had an order to self-administer the cream. Nurse N reported that it should not have been left in the resident's room. 49083 R813 On 5/7/24, a clinical record review revealed R813 was admitted to the facility on [DATE] for history of a stroke resulting in left hemiparesis (unable to move left side of body), requiring a suprapubic catheter (tube surgically placed into the bladder to remove urine), chronic kidney disease, hypertension, enlarged prostate, and a psychiatric history of depression. A brief Interview for Mental Status (BIMS) conducted on 4/22/24 revealed R813 scored a total of five indicating severe cognitive impairment. On 5/7/2024 at 11:40, upon initial introduction, R813 was observed in a contracted position lying in bed watching television, orientated, and conversing appropriately. On the bedside table, a large clear bottle, half full of a blue colored liquid was observed and further identified as GaviLyte (an oral medication given to cleanse the bowel) and a bottle of Ammonia Lactate lotion (used to treat dry, scaly, skin conditions) R813 indicated both medications have been sitting on the table for a long time. R813's assigned nurse Licensed Practical Nurse (LPN) B came to the room and when questioned about the medications, LPN B acknowledged that both medications should not have been left and removed from R813's bedside table. Further observation of the GaviLyte bottle revealed the medication was dispensed on December 11, 2023. On 5/8/24 at 2:45 PM, The Director of Nursing (DON) acknowledged medications are not been to be left at the bedside and indicated that the staff had informed the DON of the findings prior to our discussion. (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 facilities Medication Access and Storage Policy Adopted 07/11/2018 states .It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to Intake: MI00142560, MI00144323 Based on observation, interview and record review, the facility failed to administer a pre-procedural medication per physician orders for one resident (R813) resulting in termination of a diagnostic procedure. Findings include: On 5/7/24, a clinical record review revealed R813 was admitted to the facility on [DATE] for history of a stroke resulting in left hemiparesis (unable to move left side of body), requiring a suprapubic catheter (tube surgically placed into the bladder to remove urine), chronic kidney disease, hypertension, enlarged prostate, and a psychiatric history of depression. A Brief Interview for Mental Status (BIMS) conducted on 4/22/24 revealed R813 scored a total of five, indicating severe cognitive impairment. On 5/7/2024 at 11:40 AM, upon initial introduction, R813 was observed in a contracted position laying in bed watching television, orientated, and conversing appropriately. On the bedside table, a large clear bottle, half full with a blue colored liquid was observed and further identified as GaviLyte (an oral medication given to cleanse the bowel) and a bottle of Ammonia Lactate lotion (used to treat dry, scaly, skin conditions) R813 indicated both medications have been sitting on the table for a long time. R813's assigned nurse Licensed Practical Nurse (LPN) B came to the room and when questioned about the medications, LPN B acknowledged that both medications should not have been left and removed from R813's bedside table. Further observation of the GaviLyte bottle revealed the medication was dispensed on December 11, 2023. Record review revealed on 12/6/23 a physician ordered Golytetly Oral Solution (GaviLyte is the generic version) with specific instructions to drink 8 Ounces (Oz) every 15-20 minutes until gone and stools are clear. Further review the Medication Administration Record (MAR) revealed documentation this medication was administered on December 12, 2023, by LPN D. On 5/8/24 at 8:58 AM, the Director of Nursing (DON) was interviewed and informed of the medications left at R813's bedside. The DON was further informed that the half full container of GaviLyte medication has been left at the bedside since December 2023 and was documented that staff administered on 12/12/23. The DON was unable to locate results from the procedure scheduled on 12/13/24 and provided the follow up order from the gastrointestinal physician and revealed the scheduled colonoscopy procedure was aborted due to poor preparation. Review of the facility's Medication Administration Policy adopted 07/11/2018, updated 12/19/2019 stated .It is the policy of this facility that medications shall be administered as prescribed by the attending physician .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00143440. Based on observation, interviews, and record reviews the facility failed to ensure the facility staff consistently identified worsening of pressure wounds, accurately assessed/identified pressure wounds, and timely/accurately implemented treatment for pressure wounds for one (R803) of one resident reviewed for wound care, resulting in an infection to the left heel wound that required intravenous (IV) antibiotics. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of proper wound care for R803. On 5/8/24 at approximately 2:30 PM, R803 was observed lying on their back in bed sleeping. R803 was observed to have a pink tie-dyed shirt with a green comforter covering their lower body. R803 did not open their eyes to verbal stimuli and continued to sleep. Review of the medical record revealed R803 was initially admitted to the facility on [DATE] with a readmitted [DATE], with diagnoses that included: Chronic kidney disease (Stage 4), gastrostomy, epilepsy a neuromuscular dysfunction of bladder. Review of a Nursing Admission Screening/History dated 5/10/23 at 6:10 PM, documented no skin impairments. Review of an admission Nursing note documented in part . has L (left) posterior calf stage III (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole-rolled wound edges are often present. Slough and/or eschar may visible but does not obscure the depth of tissue loss) . measuring 9.0x1.5x0.2 . R (right) posterior calf stage IV (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) . measuring 2. 3x0.7 . sacral stage IV . measuring 8.5x13.5.1.5 . Resident as fungal rash to mid back . Review of a Braden scale for predicting pressure sore risk dated 5/10/23, documented Very High Risk with a score of 9.0. Review of the physician orders on 10/5/23, documented a treatment for cleansing of the left heel with normal saline, then apply betadine gel to wound bed and pad with abd (abdominal dressing)/kerlix, three times a week and prn (as needed) was ordered, however a start date was not noted. Review of the medical record revealed no documentation of a wound identified to the left heel or the characteristics of the wound to the left heel. Review of a physician order, documented to cleanse left lateral heel with normal saline, then apply betadine gel onto wound bed, pad with abd/secure with kerlix, to be done three times a week and prn was ordered on 10/12/23 and started. This order was implemented a week after the initial physician's order on 10/5/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes documented the following in part: On 10/12/23 L heel DTI (deep tissue injury- Intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration due to damage of underlying soft tissue). On 11/3/23 open area to left heel On 11/13/23 L heel DTI deteriorating with 100% eschar Review of the November 2023 Medication Administration Record (MAR)/ Treatment Administration Record (TAR) documented the following treatment: Betadine Eternal Solution, Apply to L heel topically every day shift for wound care cleanser with ns (normal saline), apply betadine-soaked gauze or ointment, cover with ABD (abdominal) and kerlix 3x week and PRN (as needed). This order was supposed to be applied on 11/4/23, however was not and documented as applied on 11/5 and 11/6/23 and not applied again on 11/7/23. Review of a Wound Consultation dated 11/9/23, documented the following in part . Lateral Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed . wound encounter measurements are 2.5cm (centimeters) length x 2.5cm width with no measurable depth, with an area of 6.25 sq (square) cm . The wound margin is undefined Wound bed has 76-100% eschar. The wound is deteriorating . Left, Lateral Heel . Wound Cleansing- Normal Saline, Primary Dressing- Medihoney/Manuka Honey, Secondary Dressing ABD pad, Kling/kerlix, Dressing Chage Frequency- PRN, 3x per week . Review of the physician orders and TAR/MARS for November 2023, revealed the treatment to the left heel did not start as directed by the wound clinician until 11/14/23, five days after the wound clinician changed the treatment. Review of a Wound Consultation note dated 12/7/23, documented the following in part, . Lateral Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed . wound encounter measurements are 4.5cm length x 3.4cm width, with an area of 15.3 sq cm. There was no drainage noted. The wound margin is undefined Wound bed has 76-100% eschar. The wound is stable . Review of the progress notes revealed R803 was transferred to the hospital on 12/8/23 for a PEG (Percutaneous Endoscopic Gastrostomy) tube replacement, however the resident was admitted to the hospital. Review of the hospital records revealed the following: (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a surgical wound consultation dated 12/10/23 at 9:57 AM, documented the following in part, . She was found to have multiple wounds on nursing admission skin assessment . This patient is known to our service . wounds last evaluated by our service on 10/30/23 . was treated with . bilateral heel wounds with non-sting barrier wipes . Left heel. (Unstageable pressure injury- Full-thickness skin and tissue loss in which the extent of tissue damage withing the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar)- present on admission . Measurements: 6cm x 7.5cm. Unable to determine the wound depth. Base: Open, moist, tan/black necrotic base. Drainage: There is moderate creamy . The wound is malodorous (unpleasant offensive odor) . Right heel. (Deep tissue injury)- present on admission. Measurements: 2.5cm x 2.2cm. Unable to determine the wound depth. Base: Area of purple/black non-blanching intact skin . Xerotic (dry scaly appearance skin) surrounding skin with no erythema . Review of an Infectious Disease consultation dated 12/11/23 at 9:51 AM, documented in part . ABT (antibiotic) management, wounds/urine . Although all wounds show progression, L heel wound is most severe. It is unstageable, with necrotic base and malodorous discharge . Will do XR (x-ray) of L foot. Considering progression of wound and active drainage, suspecting osteomyelitis of calcaneus. Will likely start empiric treatment for osteomyelitis even if XR negative due to severity of wound . Limiting antibiotics prior to podiatry evaluation for possible L heel debridement is best to ensure proper deep wound cultures, However low threshold to restart antibiotics if clinically deteriorating . Review of a Podiatry Consultation dated 12/11/23, documented in part . Reason For Consultation: Infected left heel wound . It is a soft boggy eschar with malodorous serous drainage emanating from the periphery of this wound . A deep tissue injury is noted on the right heel. It is an area of purplish-black discolored skin that is nonblanchable. The skin is intact . On the posterior aspect of the left heel, there is a soft, boggy eschar formation noted. It is an unstageable pressure wound. It measures 5.6 cm x 7.5 cm. There is a malodorous serous drainage emanating from the periphery of this soft, boggy eschar formation . I applied 5% topical lidocaine anesthesia to this area x20 minutes. I then sharply excisionally debrided the necrotic, soft, boggy eschar formation in the posterior aspect of the left heel using a sterile #10 blade utilizing aseptic technique. An underlying stage IV pressure wound is noted. There was necrotic, slough tissue, and devitalized subcutaneous tissue at this area . the bone itself was soft. It is most likely infected . Post-excisional wound debridement measurements 5.9 cm x 7.5 cm deep to the level of the calcaneus bone . This indicated the facility staff and wound team failed to identify the worsening of R803's left heel wound and failed to identify the development of the right heel wound. The was no documentation of the facility staff to have informed R803's representative of the worsening of left heel wound or the development of the right heel wound. Review of the medical record documented R803 was readmitted to the facility on [DATE]. Review of the readmission nursing assessment dated [DATE] at 5:56 PM, documented in part . Decubitus ulcer of sacral region, decubitus ulcer of right leg, pressure injury right heel, decubitus ulcer of R&L (right and left) ischium . The assessment failed to identify the left heel wound. Review of the physician orders revealed no treatment implemented for the left or right wound heels until two days later on 12/20/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the December 2023 MAR/TAR documented the following in part, . Triad Hydrophillic Wound Dress External Paste (Wound Dressings) Apply to Bilat (bilateral) heels topically every shift for wound treatment. Cleanse with wound cleanser remove excessive residual Triad before application. Apply thick layer of Triad ointment to cover bilat heel wounds. Cover with dry flat 4x4 gauze and secure with kerlix and medipore tape . Started on 12/20/23. Review of a Wound Consultation dated 12/21/23, documented in part, . Left, Lateral Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed . wound encounter measurements are 6cm length x 6.5cm width, with an area of 39 sq cm. There was no drainage noted. The wound margin is undefined Wound bed has 76-100% eschar. The wound is stable . Orders . Cleansing- Normal Saline . Dressing- Medihoney/Manuka Honey . Secondary Dressing- ABD pad, Kling/kerlix . Frequency- PRN, 3x per week . The right heel wound was not identified or assessed. This indicated the Wound Consultation was not an accurate assessment as the left heel wound was diagnosed as a Stage IV wound at the hospital and review of the medical record revealed the resident was currently on Intravenous (IV) antibiotics for the left heel wound infection (for 38 days) at the facility. Review of the December 2023 MAR/TAR documented the treatment as directed by the wound clinician on 12/21/23 was not implemented as directed. Review of a Wound Consultation dated 12/28/23, documented in part . 12/28: Patient returned back to the facility after being discharged from the hospital . currently on IV ABX (antibiotics). New DTI noted to right heel . Left, Lateral Heel is a Deep Tissue Pressure Injury . 6.5 cm length x 6cm width, with no measurable depth, with an area of 39 sq cm. There is a Small amount of fresh blood drainage noted which ha no odor . 51-75% eschar . Right Heel is a Deep Tissue Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurement are 2.5cm length x 2.2cm width with no measurable depth, with an area of 5.5 sq cm . Wound Orders . Left, Lateral Heel . Wound Cleansing- Normal Saline, Primary Dressing- Medihoney/Manuka Honey, Secondary Dressing- ABD pad, Kling/kerlix . PRN, 3x per week . Right Heel . Wound Cleansing- Acetic Acid, Primary Dressing- Medihoney/Manuka Honey, Secondary Dressing- Bordered foam, Dressing Change Frequency- PRN, 3x per week . Review of the Physician orders, December 2023 MAR/TAR and January 2024 MAR/TAR documented did not implement the right and left heel wound orders as directed by the wound clinician. The previous Triad Hydrophillic Wound Dress External Paste order stayed implemented for both heels until it was discontinued on 1/4/24, two weeks after the order was originally changed by the wound clinician. Review of the January 2024 MAR/TAR revealed orders implemented on 1/6/24- Medihoney Gel to the right heel topically every Tuesday, Thursday, and Saturday. This was not wound order directed by the wound clinician. Further review revealed an order to the left hell for Medihoney every Tuesday, Thursday and Saturday implemented on 1/6/24, which is also not the exact order as directed by the wound physician. This order was discontinued on 1/17/24 and new orders was not implemented until 1/20/24 for both the left and right heels, resulting in no treatment to the heels for three days. Review of a Wound Consultation dated 2/1/24, documented a Unstageable Pressure Injury to the right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Wound Consultation dated 2/29/24, documented a . Transfer of Care . for the right and left heel wounds. Podiatrist that will be moving forward in managing patient's chronic wound. Wound care is signing off . No further wound assessments, consultations or follow-up care identified in the medical record. On 5/8/24 at 3:13 PM, the Director of Nursing (DON) and Wound Nurse (WN) O was asked to provide any documentation or consultation regarding R803's left and right heels from 2/29/24 when they were discharged from the wound consultant's services. Shortly after, WN O provided one consultation dated 3/11/24. Review of a . Foot Clinic & Wound Care Center consultation dated 3/11/24, documented in part . Bilateral heel wounds - please apply Santyl to the black, necrotic, fibrotic tissue. Change dressings daily. If there is excess drainage, change dressing twice per day. Her heels must be floating at all times. They are not to leave the offloading boots. While in bed keep a pillow under her calf just above the wound to float heels from bed. If skin gets macerated, apply betadine to this area prior to dressing. Follow up next week . No other consultations from this Foot and Wound clinic were provided by the DON or WN O and no further consultations were identified in the medical record. Review of the medical record revealed on 3/15/24 the resident was transferred to the hospital for decreased urine output and acute kidney injury. Review of a Medical ICU (Intensive Care Unit) consult dated 3/15/24, documented in part . Bilateral heel wounds with necrotic eschar and mucopurulent discharge . Review of a Podiatry consult dated 3/18/24, documented in part . A 10.0 cm x 8.0 cm stage IV pressure wound is noted on the posterior aspect of the left heel. A 6.5 cm x 4.0 cm stage IV pressure wound is noted on the posterior aspect of the right heel . Both wounds were tender to direct pressure as the patient did open her eyes when I was palpating the heel wounds and she was making facial gestures with pressure applied to both heels, even while being intubated . A soft, boggy, black eschar formation was noted on the posterior aspect of both heels . An extensive amount of malodorous purulent discharge was noted from the left heel stage IV pressure wound. Some serosanguineous drainage was noted from the right heel stage IV pressure wound . They both extended deep to bone and calcaneus bone was exposed on the posterior aspect of each of the heels. Clinically, each of these wounds were considered to be actively infected due to the exposed calcaneus bone as well as the purulence and [NAME] pus from the left heel wound . Review of the medical record revealed the resident was readmitted on [DATE]. Review of a Wound Consultation dated 4/16/24, documented a . Right Heel . Unstageable Pressure Injury . Which was not an accurate assessment as the wound was already staged at a stage IV during their hospitalization . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/8/24 at 11:34 AM, WN O was interviewed and asked the facility's process on the ordering and implementation of the wound clinician wound orders and WN O explained they had started employment with the facility in February 2024, however they explained that they would complete wound rounds with the wound clinician weekly. Once completed with the rounds or after the resident's assessment they would order and implement the resident wound orders as directed by the wound clinician. WN O was asked why the wound orders were not implemented timely and accurately and asked about the inconsistent wound assessments. WN O stated they would check into it and follow back up. On 5/8/24 at 3:13 PM, the Director of Nursing (DON) was also, asked why the facility staff failed to identify the worsening of R803's heel wounds, timely/accurately implement the orders as directed by the wound clinician, and accurately and consistently completed wound assessments. The DON explained the facility employed a different wound nurse until about December 2023, when the previous wound nurse resigned. The DON stated the facility had recently been undergoing a big transition. The DON stated they would look into it and follow back up. At 5:34 PM, the DON returned and stated the Facility's Quality and Assurance program had identified skin concerns at the facility. The DON was asked if they had identified any skin concerns with R803 and the DON showed that resident R803 was picked up on one of the skin audits, however the staff documented no concerns. The DON was then asked if they felt their skin audits were effective considering the audit/staff did not identify the concerns of the skin impairments with R803 and the DON stated the audits are a concern and is currently still ongoing. No further explanation or documentation was provided by the end of the survey.

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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** 41415 This citation pertains to intake: MI00143440. Based on observation, interviews, and record reviews the facility failed to ensure an accurate placement of a urinary catheter foley for one R803 of two residents reviewed for a urinary catheter. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part, . Resident's foley catheter was improperly inserted on 3/14/2024 and resident had to be transported to hospital on 3/15/2024. This is the 2nd time this has occurred . On 5/8/24 at approximately 2:30 PM, R803 was observed lying on their back in bed sleeping. R803 was observed to have a pink tie-dyed shirt with a green comforter covering their lower body. R803 did not open their eyes to verbal stimuli and continued to sleep. A urinary catheter bag was observed on the lower right side of the bed, draining clear yellow urine. Review of the medical record revealed R803 was initially admitted to the facility on [DATE], a readmitted [DATE], with diagnoses that included: Chronic kidney disease (Stage 4), gastrostomy, epilepsy, and neuromuscular dysfunction of bladder. Review of a Nursing Note dated 3/14/24 at 7:14 PM, documented in part . Writer watched other nurse replace per NP (Nurse Practitioner) order 16 fr (French) catheter foley replaced with 15cc residual return. Resident tolerated procedure. Review of a Physician Services note dated 3/15/24 at 5:04 PM, documented in part . Per nursing staff, pt (patient) had minimal output x 1 day ago. Pt seen and examined today. Pt remains obtunded (having a reduced level of consciousness/alertness) w (with)/a subtle grunting noted . Acute oliguria (low urine output)-new-limited urine output in the past 24 hrs (hours). No results found for renal US (ultrasound). Due to Oliguria coupled w/severe AKI (acute kidney injury) send to ED (emergency department) w/ for further [NAME]. (evaluation). Review of an EMS (emergency medical services) transport record dated 3/15/24 at 9:27 AM, documented in part . Upon arrival found pt (patient) laying supine in bed unresponsive to painful stimuli . was called for no pt urine output for over a day. When staff rolled her to change her, we noticed pt's Foley catheter wasn't even place in her . Review of an Emergency Medicine consultation dated 3/15/24 at 9:53 AM, documented in part . presents to the ED from her skilled nursing facility with altered mental status . Nursing staff stated that there was decreased urinary output. However, when EMS arrived the Foley was not even in place . Review of a Medical ICU (Intensive Care Unit) consult dated 3/15/24 at 12:00 PM, documented in part . new foley was inserted [NAME] pus versus white-colored sediment was immediately expressed . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 3:13 PM, the Director Of Nursing (DON) was interviewed and asked about R803's urinary catheter that was observed by the EMS to have been incorrectly placed. The DON stated they would look into it and follow back up. On 5/8/24 at 5:32 PM, Nurse P (the nurse assigned to R803 on 3/15/24 when the resident was transferred to the hospital) was interviewed and asked if they could recall any issues/concerns with R803's foley catheter and Nurse P denied to have identified any concern/issues with R803's catheter before they were transferred to the hospital. At 5:34 PM, the DON returned and referred to the Medical ICU (Intensive Care Unit) consult dated 3/15/24 at 12:00 PM, documented in part . Per ER resident there was a Foley loose when patient presented; when new foley was inserted [NAME] pus versus white-colored sediment was immediately expressed . No further explanation or documentation was provided by the end of the survey.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake #MI00142366 Based on interview and record review the facility failed to ensure a resident received ordered pain medication in a timely manner for one (R812) out of one resident reviewed for pain, resulting in a significant increase in pain (10/10). Findings include: A complaint was filed with the State Agency (SA) that alleged R812 did not receive scheduled pain medication and after telling the nurse they were in extreme pain, the nurse noted told them honey you can make it through the night. A review of R812's clinical record documented the resident was admitted to the facility on [DATE] with diagnoses that included: aftercare following joint replacement surgery. The resident's initial assessment indicted the resident was cognitively intact. Continued review of R812's clinical record revealed, in part, the following: Medical Practitioner Note (1/18/24 at 6:38 PM): .Pt (patient) comes to this facility for rehab therapy and medical management. Pt. seen today and examined today. Pt reports knee pain 8/10 at bedside .Continue Morphine and Oxycodone as ordered .Morphine Sulfate ER Extended Release 15 MG give 1 tablet by mouth every 12 hours for pain .Oxycodone Extended Release (ER) .20 MG give 1 tablet by mouth every 12 hours for moderate to severe pain . Medical Practitioner Progress Note (1/19/24 at 6:50 PM) Late entry . Pt seen an examined today. Pt reports uncontrolled pain and current pain score of 10/10. Pt reports she is not receiving her proper pain meds .Pt states that she is leaving when her sister arrives . Case d/w (discussed with) nursing to administer pain meds ASA (as soon as) . A review of the resident's Medication Administration Record (MAR) noted that that the following controlled substance/narcotic medications were administered on 1/18/24: Morphine Sulfate Extended Release 15 MG (milligrams) give 1 tablet by mouth every 12 hours for pain. Given on 1/18/24 at 9:00 AM (signed by Nurse H) and 9:00 PM (signed by Nurse I). Oxycodone 20 MG give 1 tablet by mouth every 12 hours for moderate to severe pain. Given on 1/18/24 at 9:00 AM (signed by Nurse H) and 9:00 PM (signed by Nurse I). On 5/8/24 at 10:55 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to whether R812 received their ordered pain medication as noted on the MAR. The DON reported that the medication had been ordered but had not yet arrived at the facility and the nurses needed to obtain the medication from their backup box. The DON further reported that they had determined that Nurse I did not provide the medication (Morphine and Oxycodone) to R812 on 1/18/24 at 9:00 PM as noted in the MAR. When asked if Nurse H provided the medication (Morphine 15 MG and Oxycodone 20 mg) at 9:00 AM as noted in the MAR, they replied that to their knowledge the resident did receive the medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was made to provide documentation that the controlled substance medications were pulled from the backup box by Nurse H on 1/18/24 at 9:00 AM as noted in the MAR. The only document provided by the facility was a form titled, Transaction by Employee and Witness that noted Morphine 15MG was pulled by Nurse H and witnessed by Nurse J on 1/19/24 at 8:39 AM as it was noted that Nurse I never gave the medication. No documents were provided as requested for 1/18/24 by the end of the Survey. A phone interview was conducted with Nurse I on 5/8/24 at approximately 2:55 PM. When asked about the medication that was noted as given in R812's MAR, Nurse I reported that they checked it was given in error as it was a very busy evening. It should be noted that Nurse I no longer works at the facility. A phone interview was conducted with Nurse H on 5/8/24 at approximately 2:49 PM. When asked if they recalled providing (Morphine 15 MG and Oxycodone 25 MG) to R812 on 1/18/24 and whether the medications were signed out and witnessed by nursing staff, they indicated that they recalled pulling the medication from the backup box but the resident refused the medication and left the facility. A review of the facility policy titled, Pain Management (7/11/18) documented, in part: Policy- It is the policy of this facility to provide an environment and programs that assist each resident to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . Procedure: The resident will be assessed for pain .Management .Medications received, refused and response to medication will be documented on the MAR .

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake #'s: MI00143426 and MI00144086. Based on observation, interview and record review the facility failed to ensure resident's received timely dental services, including denture replacement and tooth extractions for one (R802) out of three residents reviewed for dental care. Findings include: Complaints were filed with the State Agency (SA) that alleged residents were not receiving dental care and dentures were not replaced timely. R802 On 5/7/24 at approximately 10:05 AM, R802 was observed lying in bed. The resident was alert and could answer some questions asked. When asked about care provided in the facility R802 reported that they needed to seek services outside of the facility and further noted that they needed to have two molars removed. When asked if their teeth caused pain, R802 reported they hurt at times. R802 also noted that their dentures were stolen and needed to be replaced. A review of R802's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: schizoaffective disorder, bipolar disorder and type II diabetes. The resident was noted to have a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). Continued review of R802's clinical record documented, in part, the following: (Name redacted) Dental Group (7/20/23): R802 .Delivered maxillary complete denture .Encourage to wear denture . (Name redacted) Dental Group (8/10/23): R802 .Patient had crown #30 (bottom right molar) come off . reveals non-restorable distal cervical decay. Informed patient #30 will need extraction by Oral Surgeon . (Name redacted) Dental Group (3/27/24) R802 .Patient needs new upper dentures, states that his were stolen. #31 (bottom right molar) and #30 non-restorable decay into the pulp (nerves/blood tissue). Refer to OS (surgeon) for extractions and prior authorization sent for new dentures last ones delivered on 7/20/23). Following review of the Dental Group care in R802's record, no documents were found that indicated the residents dentures were stolen and/or the resident was scheduled for oral surgeon for extractions of teeth #30 and #31. On 5/7/24 at approximately 12:49 PM, a request for any IA (incidents/accident) reports and/or grievances for R802 was sent via e-mail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. Building B. Wing	05/08/2024

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A grievance dated 10/11/23 was provided and documented, in part: Date of Report: 10/11/23 . Received by Social Worker(SW) K .Name: R802 .Describe Grievance or Satisfaction .Social Worker received voicemail from resident reporting that the staff stole his dentures and took them to a pawn shop to sell them . Investigation: SW spoke with Kitchen Manager and Housekeeping Director to inquire if dentures were found on tray or in laundry - both advised NO .Resolution: BLANK .Notifications: Date Resident Notified of Resolution: BLANK .Administrator Signature: BLANK . On 5/7/24 at approximately 3:43 PM, a phone interview was conducted with SW K. SW K was asked as to their role in ensuring ancillary services, including dental care, was provided to residents. SW K noted that they were responsible for ensuring in house ancillary services were provided. When asked about the grievance form dated 10/11/23 that alleged R802's dentures were stolen and appeared not to be completed with any resolution, SW K noted that they did not recall what was done. When asked about the dental recommendation on 8/10/23 and again on 3/27/24 that noted the resident needed two teeth extracted and reported that their denture was stolen, SW K reported that they do not schedule outside services and stated that it is the responsibility of Staff Scheduler L to ensure outside healthcare services are scheduled. SW K was asked as to their role in ensuring services are scheduled by Staff L as the Dentist notes indicate that an extraction was recommended on 8/10/23 and again over seven months later on 3/27/24. SW K' again noted that they do not schedule those services and recommended talking with Staff L. On 5/7/24 at approximately 4:00 PM, an interview was conducted with Staff L. Staff L confirmed that they are responsible for scheduling outside services. Staff L was asked about R802's need to have two teeth extracted and follow-up denture replacement. They reported that they were aware that the resident needed to have their teeth extracted and needed their dentures replaced. When asked if anything had been scheduled, they reported that it was difficult to schedule the appointments as the resident needed to be taken by stretcher and due to their insurance coverage they needed to be sent to a specific oral surgeon. When asked to provide any documentation that they attempted to schedule the appointments, Nurse L reported that they did not have any documents that would indicate they attempted to schedule and/or if any appointments had been scheduled. Nurse L further indicated that they were also waiting for the residents Durable Power of Attorney (DPOA) to consent to the dental treatments. *It should be noted that R802 was noted as their own responsible party and had signed consent for psychoactive medication on 3/4/24. The facility policy titled, Dental Services was reviewed and documented, in part: Policy: It is the Policy of this facility to ensure routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care . Routine and 24-hour emergency dental services are provided to our residents through . Selected dentists must be available to provide follow-up care Social Services representatives will assist residents with appointments, transportation arrangements and for reimbursement of dental services under the state plan .direct care staff will assist residents with denture care . If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink .and the reason for the delay. All dental services provided are recorded in the resident's medical record .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to Intake: MI00144086. Based on observation, interview, and record review, the facility failed to perform hand hygiene consistent with accepted standards resulting in the potential for transmission of infectious material. Findings include: A review of Intake MI00144086 indicated the complainant was concerned about cross contamination with R801's tracheostomy tube (a medical device surgically inserted into a hole in the neck to help a person breath).The staff touch everything in the room and then provide trach care . Further concerns included toe fungus, and skin breakdown on the buttock area. The complainant was present at the facility on 5/7/24 and confirmed the allegations. On 5/7/24, A clinical record review revealed R801 was recently readmitted to the facility on [DATE] for a history of stroke with intracerebral hemorrhage (bleeding in the brain), required a tracheostomy related to impaired breathing mechanics, and a Percutaneous Endoscopic Gastrostomy (PEG) Tube (surgically placed tube into the stomach to deliver nutrition) due to dysphagia (inability to swallow) and is incontinent of bowel and bladder functions. On 5/7/24 at 12:45 PM, a skin assessment observation was performed with Registered Nurse (RN) C. R801 was placed on his back in the bed, both shoes and socks were removed to expose both feet. RN C then separated the toes individually with gloved hands to allow visualization in between the surface areas. The toenails were observed pale yellow colored and thick. R801 was then rolled onto his right side and an incontinent brief was removed exposing the buttocks, RN C placed same gloved hands around the buttocks and revealed a moderate reddened rash like area. A comment was made to RN C, once R801 was changed into a shirt, the area around the tracheostomy site would need to be observed. RN C proceeded to have R801 sit up and then manipulated around the tracheostomy area and removed the gauze covering the opening into the neck without changing gloves that were used when touching R801's feet and buttock areas. The complainant was present during the assessment and became upset at RN C when it was identified that gloves and hand hygiene were not performed in between touching the feet and buttocks prior to touching around the tracheostomy site. At that time, RN C removed gloves, and replaced with another pair and did not wash hands. On 5/8/24, at 2:40 PM, The Director of Nursing (DON) was informed of improper hand hygiene and acknowledged gloves should have been changed with hand hygiene after handling R801's feet and buttocks. The DON revealed that RN C is afraid of the complainant and probably was nervous hence why the hand hygiene was not performed. Review of the facilities policy Hand Hygiene Updated 3/24/22 states .It is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infection .Healthcare personnel should use an alcohol-based hand rub or wash with soap and water before performing an aseptic task or handling of invasive medical devices .