STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235226	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Blanc	11941 Belsay Rd Grand Blanc, MI 48439

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake MI00148741 Based on observation, interview and record review, the facility failed to ensure dignified and respectful care and treatment for two (# 4 and 61) of two residents and five of five residents observed during the dining task resulting in lack of supervision during meals as care planned for one resident (R39) and availability of equipment during dining, Resident #4 being exposed during care, and Resident #61 expressing delayed staff response to needs, unnecessary incontinence, discourteous and rude staff, lack of adaptive communication devices, and Resident verbalization of feelings of fear, anxiety, and frustration. Findings include: Resident #61 (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 12:04 PM, Resident #61 was observed in their room laying in in bed with their eyes open wearing a hospital style gown. Resident #61 was receiving mechanical ventilation via a tracheostomy. When spoke to, Resident #61 responded by mouthing words without making sound. Resident #61 had a cell phone on their bed. When asked if they were able to write and/or type, Resident #61 indicated they could. A method for written communication such as a white board and/or paper, pen and/or pencil were not present in the room. When queried regarding staff responsiveness to call lights, Resident #61 responded, Long time to answer call lights. The Resident gestured toward their tracheostomy and ventilator and mouthed, I could die! Resident #61 was asked if they had anything to write with in their room and shook their head to indicate they did not. The Resident was able to type responses on their phone. When queried regarding the call light response times, Resident #61 responded, It takes them too long. When asked how long the call light wait times are and if there are any times of the day/week which are worse, Resident #61 responded, It depends on who's working. Some are really good and others not so much. With further inquiry, Resident #61 revealed first shift is bad and third shift is too. Resident #61 revealed staff will enter their room and turn off their call light without addressing their needs, and not return to help them. A bedside commode was observed in the Resident's room. The commode had items sitting on top of the closed seat and appeared unused. When asked if they used the commode, Resident #61 revealed they had only used the commode once. When asked if they knew when they needed to use the restroom, Resident #61 confirmed they did. Resident #61 then revealed that due to being dependent upon the ventilator, they require assistance to get out of bed and to use the restroom. Resident #61 stated they put on their call light when they need to use the restroom, but the staff do not respond in time. When queried if they were saying they had accidents (incontinence) due to lack of timely assistance by staff, Resident #61 shook their head to indicate yes. When asked how that makes them feel, Resident #61 revealed they felt embarrassed. Resident #61 conveyed further feelings of frustration. When queried if the staff treat them with dignity and respect, Resident #61 shook their head to indicate no. Resident #61 stated, A few CNA's (Certified Nursing Assistants) bedside manners can improve and a couple of nurses. The language that they use is very unprofessional. At this time, a staff member opened the Resident's room door without knocking or announcing themselves and Resident #61 gestured towards the staff member. At 12:50 PM on 1/8/25, an interview was completed with Resident #61. When queried regarding prior statement related to staff having poor bedside manners, Resident #61 wrote, I had some tubes come off of my trach (tracheostomy to ventilator), and a nurse literally said she thought I took it off for attention. Resident #61 continued, Why would I do that? I couldn't get it back on and the Respiratory Therapist (RT) had to come and reconnect me. Resident #61 continued, Sometimes the tubing comes off and I do my best to get it back on, but I want RT to check it but if the (ventilator) alarm doesn't go off and an aide waits to come in, it (tracheostomy/ventilator tubing) pops off. It has popped off five times before. When queried how it makes them feel when their ventilator tube becomes disconnected, Resident #61 indicated it was scary. When asked how it made them feel when the nurse told them they thought they disconnected the tubing for attention, Resident #61 conveyed they were very upset and reiterated they may die without the ventilator to breathe for them. When queried if they knew the name of the nurse who said that to them, Resident #61 revealed it was a third shift nurse, but they did not know their name. When queried regarding activities, Resident #61 revealed they would like to be able to get out of their room and go to the small lounge to read or puzzles. When asked, Resident #61 indicated there is not enough staff for them to be able to go to the small lounge and stated, The only other option is to sit in the hallway by the respiratory therapist office. That doesn't work for me. I don't want to be a spectacle. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses with included dysphagia (difficulty swallowing), anxiety, end stage renal disease with dialysis dependence, gastrostomy (surgically created opening through the abdominal wall into the stomach for the introduction of nutrition), aphonia (loss of voice), tracheostomy (surgically created opening in the throat to allow air to pass into the lungs), and respiratory failure with ventilator (machine which supports and/or breaths for an individual when they are unable) dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, had unclear speech, and required maximum to total assistance with transferring, bathing, and toileting. The MDS further revealed the Resident was frequently incontinent of bowel and bladder and was not on a toileting program. Review of Resident #61's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an ADL self-care performance deficit related to presenting to ED with respiratory distress, leading to intubation and tracheostomy (3/14/24), followed by vent . (Initiated: 5/8/24; Revised: 7/30/24). The care plan included the interventions: - Resident uses a wheelchair with cushions (Initiated: 5/10/24) - Toileting: 2-person extensive assist (Initiated: 5/10/24; Revised: 8/15/24) - Transfers . 2-person extensive assist (Initiated: 5/9/24; Revised: 5/10/24) Another care plan entitled, Resident is at risk for impaired communication related to tracheostomy, Ventilator use. Resident is able to write needs on paper, mouth words (Initiated: 5/10/24; Revised: 5/15/24). The care plan included the interventions: - Allow ample time for the resident to comprehend what is being communicated and allow time for response (Initiated: 5/10/24) - Anticipate and meet the resident's needs (Initiated: 5/10/24) On 1/9/25 at 12:04 PM, Resident #61 wrote, It's happening right now. I turned my light on at 11:19 AM. At 11:35 AM, someone came in and went to look for my aide (CNA). Resident #61 continued, Since then, the Respiratory (Therapist) came in (room) to do their part. Resident #61 revealed they put their call light on because they needed to use the restroom and now needed to be changed. Resident #61 revealed they also wanted to get out of bed. On 1/9/25 at 12:30 PM, an interview was completed with Resident #61 and the Director of Nursing (DON). Resident #61 was in their room, sitting in bed wearing a hospital gown. When queried if a staff member had been in to assist them, Resident #61 revealed a CNA had just left the room. Resident #61 reiterated all concerns to the facility DON at this time including having to wait an hour for assistance today. Resident #61 further stated they were still waiting for assistance to get into their wheelchair and revealed they did not like sitting in bed all day. An interview was conducted with the DON after exiting the Resident's room. When queried regarding Resident #61's concerns, the DON acknowledged the validity of Resident #61's concerns and verbalized that the concerns would be addressed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:43 PM on 1/9/25, Resident #61 wrote, I'm still not in my chair and I told (CNA) I didn't feel cleaned well. (The CNA) told me give her a minute after I already waited an hour. It's been 2.5 hours I been waiting. On 1/9/25 at 2:12 PM, Resident #61 wrote, My old aide was so sweet to come in and changed me and got me in the chair. her name is (CNA G). Resident #61 revealed their assigned CNA had not returned to assist them. An interview was completed with the DON on 1/9/25 at 4:20 PM. The DON was informed that Resident #61 was not assisted to get into their wheelchair and was not provided incontinence care a second time as requested today. The DON verbalized understanding but did not provide further explanation. An interview and review of Resident #61's care plans was completed with the DON on 1/14/25 at 1:08 PM. When queried regarding the Resident's communication care plan, the DON responded the Resident could write and mouth words. When asked how the Resident was able to write when they did not have paper, pencil/pen, and/or writing board in their room, the DON verbalized they could not and stated they would address the concern. 22348 FACILITY Dining Observation On 01/08/25 at 1:21 PM, R39 was observed eating his meal alone in his room. Food consist of cut up (mechanical soft) consistency. He was not assisted and was not supervised while eating his meal. R39 was ask if somebody was here to help him with his meal. He shook his head indicating no. On the walls in his room are posted swallowing precautions and instruction on what to watch for. R39 was asked if he has difficulty swallowing. He stated yes and nodded his head. R39 did not wear clothing protector and was observed with food all over his chest and his bed. Because of the swallow precaution signs up on the wall, the surveyor went out of R39's room to look for any staff to assist and verify R39 status while eating. No staff was found in 600 hall at that time. On 1/9/25 at 9:55 AM an Interviewed Nurse C was conducted. Nurse C indicated he is a peg tube for his medication and was upgraded to eating food orally. R39 has peg tube used for medication administration. R39 started eating food by mouth in pureed consistency initially and is currently level 3 texture with honey liquid. He is supervision during meals while eating and offer assistance setting up and cutting up the food. When Nurse C was asked to explain what supervision meant for Level 3 she briefly stated, someone has to be present while he eats. On 1/9/25 at 10:00 AM, an interview with RD E was conducted. RD E indicated that his diet is a Level 3 diet with flushing, and honey thickened fluid. R39's current careplan is supervision with meals and someone has to monitor, assist as needed and set up with R39's meals. He is in swallowing precaution. RD E stated I am not sure why R39 did not have a clothing protector. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident# 39 (R39) R39 was [AGE] years old with current admitted [DATE]. R39 had a diagnosis of Hemiplegia and Hemiparesis from a Stroke affecting his left dominant side, dysphagia, and generalized muscle weakness in addition to other diagnoses. His BIMS (Brief Interview of Mental Status) Score is 15/15 assessment date of 10/24/24. R39 had a careplan initiated on 7/18/2024, for Activities of Daily Living (ADL) self-care performance deficit related to history of CVA with left sided weakness and other contributory diagnoses. A Care Plan intervention for eating revealed, Supervision- offer assistance with meal set up as needed, fluid flush as ordered via peg. Date initiated was 7/22/24 and revised date was 12/2/24. 37771 Dining Observation On 1/8/25 at 1:32 PM, an observation was made of six residents getting served the lunch meal in the 300-hall dining area. Two residents had on a shirt protector that snapped at the back of the neck and were positioned to prevent food spills on their clothing while eating. An observation was made of three of the residents with a towel placed where a shirt protector would be. One resident had theirs sliding down onto their lap and exposed their shirt. Another resident had hers on one shoulder and half of the front of her shirt was exposed. At one point this resident's towel fell off her shoulder and onto the floor. The Resident picked the towel off the floor and placed it back over her chest area, the towel dropped lower on her lap, and it was not positioned to protect her clothing as she had intended. One resident was asked if she preferred a shirt protector instead of a towel, the resident indicated she was given this, indicated the towel. The resident lifted the towel up, which had some spilled food on it that went onto the residents clothing. Another resident was observed with the towel across his chest area, but it did not protect his clothing from getting soiled while he ate. On 1/8/25 at 1:56 PM, an interview was conducted with Nurse H who had been in the vicinity of the dining area. The Nurse was asked about the lack of shirt protectors for the three residents in the dining area. The Nurse stated, We only had two shirt protectors so we substituted the towels, but it's not the same as you can see. The Nurse stated, We get them dressed everyday and well, you see, indicated the towels did not protect the resident's clothing as a shirt protector would. The Nurse was asked if it was a recurrent issue and the Nurse indicated they had a newer company that launders, and they have been short at times of the shirt protectors. The Nurse reported that the towels were not the same and that it would be nice to have enough for everyone who needs one. Resident #4 A review of Resident #4's medical record revealed an admission on 7/1/20 and readmission on 11/9/21 with diagnoses that included multiple sclerosis, dementia, muscle wasting and atrophy and Alzheimer's disease. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 9/15 that indicated moderately impaired cognition, and the resident was dependent with most activities of daily living and transfers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 4:02 PM, an observation was made of Resident #4's door open about a foot wide. An observation was made from the hallway of the Resident getting transferred into a shower chair by a Hoyer lift and being placed into a shower bed that had the head of the bed elevated, so the Resident was in an upright position. The Resident was not dressed in a gown or clothing on. The resident could be visualized from the hallway. Two male residents were coming down the hall. The surveyor entered the room. An observation was made of Resident #4's roommate positioned in a wheelchair with a bedside table in front of her and facing towards the Resident getting transferred with the Hoyer lift. The curtains were not closed for privacy. CNA J was positioning a blanket over Resident #4. The CNA was asked about the open door and the CNA reported that it does not always stay closed. The CNA indicated that she had the privacy curtain pulled when she was doing care in bed but opened the curtain when she was transferring the Resident to the shower chair. The CNA was asked if the curtain was pulled to provide privacy, and it was indicated the curtain was not closed while transferring the resident to the shower chair. A review of facility policy titled, Promoting/Maintaining Resident Dignity, reviewed/revised 10/26/23, revealed, .Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . 12. Maintain resident privacy .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to develop and implement a comprehensive activity care plan for one (#61) of one resident reviewed resulting in the potential for lack of meaningful activities and decreased quality of life. Findings include: Resident #61: On 1/8/25 at 12:04 PM, Resident #61 was observed in their room laying in in bed with their eyes open wearing a hospital style gown. Resident #61 was receiving mechanical ventilation via a tracheostomy. When spoke to, Resident #61 responded by mouthing words without making sound. When asked if they were able to write and/or type, Resident #61 indicated they could. A method for written communication such as a white board and/or paper, pen and/or pencil were not present in the room. When queried about level of assistance needed to get out of bed and facility activities, Resident #61 revealed staff are not responsive to call lights and/or requests for assistance. At 12:50 PM on 1/8/25, an interview was completed with Resident #61. When queried regarding activities, Resident #61 revealed they would like to be able to get out of their room and go to the small lounge to read or puzzles. When asked, Resident #61 indicated there is not enough staff for them to be able to go to the small lounge and stated, The only other option is to sit in the hallway by the respiratory therapist office. That doesn't work for me. I don't want to be a spectacle. Record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses with included anxiety, end stage renal disease with dialysis dependence, aphonia (loss of voice), tracheostomy (surgically created opening in the throat to allow air to pass into the lungs), and respiratory failure with ventilator (machine which supports and/or breaths for an individual when they are unable) dependence. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, had unclear speech, and required maximum to total assistance with transferring, bathing, and toileting. Review of Resident #61's Electronic Medical Record (EMR) revealed the Resident did not have a care plan in place pertaining to Activities. Review or Resident #61's EMR documentation revealed a Activities Quarterly Progress Note dated 11/12/24 which specified Activity pursuits . Resident enjoys in room leisure activities . Activity Care Planning . Resident enjoys in room leisure activities . An interview and review of Resident #61's care plans was completed with the Director of Nursing (DON) on 1/14/25 at 1:08 PM. When queried if all facility residents should have a care plan in place for activities, the DON responded, Yes they should. The DON was then informed that a care plan for Activities was not present in Resident #61 EMR. The DON reviewed Resident #61's EMR and confirmed the Resident did not have a care plan for Activities. When asked why the Resident did not have a care plan, the DON was unable to provide an explanation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy/procedure entitled, Activities (Reviewed/Revised 10/30/23) revealed, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident . Policy Explanation and Compliance Guidelines: 1. Each resident's interest and needs will be assessed on a routine basis. The assessment shall include, but is not limited to . Care Plan .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake MI00148741 Based on observation, interview and record review, the facility failed to ensure the provision of the necessary services to ensure timely response and assistance for completion of Activity of Daily Living (ADL) care for three (#'s 39, 43, and 61) of seven residents reviewed resulting dependent residents not receiving timely care including repositioning, toileting, and hygiene and resident verbalization of discomfort and feelings of frustration and embarrassment. Findings include: Resident #43: On 1/09/25 at 7:59 AM, Resident #43 was observed in bed, positioned on their back with the head of the bed elevated in a high seated position. Upon entering the room, the distinct odor of urine and bowel movement were noted. The odor grew in intensity closer to Resident #43. The Resident was receiving mechanical ventilation via a tracheostomy. When asked how they were, Resident #43 replied, My neck hurt. Resident #43 was asked how long their neck had been hurting and if they had told the nurse and responded, Bed broke. When asked how long their bed had been broken, Resident #43 responded by repeating they were in pain. At this time, Certified Nursing Assistant (CNA) K was observed in the hallway and asked to come into the Resident's room. Resident #43 was heard telling CNA K they were having pain in their neck and back. CNA K proceeded to inform Resident #43 that they would be back. When queried regarding the Resident stating their bed was broken, CNA K confirmed and stated, Broke last night. When asked what was broken on the bed, CNA K revealed the bed was stuck in its current position and would not move. CNA K then stated, Can't change (Resident #43). CNA A was asked when the last time Resident #43 had received incontinence care and replied, Hasn't been changed since last night. CNA K was asked how they knew the bed was broken and revealed the night shift CNA told them during report. When asked what time Resident #43 last received incontinence care, CNA K revealed they did not know. CNA K then told Resident #43, (Maintenance Director L) will be in to fix their bed. Resident #43 cried out at this time and said, My back hurts. Please help me! CNA K walked out of the room without attempting to reposition the Resident or checking the bed function. Observation and measurement of the bed revealed the head of the bed was elevated at a 60-degree angle. A long cord was observed on the floor under the wheels and base of the overbed table. The cord went under the bed. The connection cord was disconnected from a plug box located near the bottom on the right underside the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:05 AM on 1/9/25, Unit Manager Registered Nurse (RN) M entered Resident #43's room. When queried regarding Resident #43's bed, RN M stated, I'm not sure if it's actually broke. RN M attempted to adjust and reset the bed with the controller without success and stated, It's not working. When asked how long the bed had not been functioning, RN M revealed they were just informed the bed stopped working on night shift by CNA K prior to entering the room. When queried regarding CNA K stating the Resident had not received incontinence care since last night, due to the bed being broken, RN M did not provide further explanation. When queried if the facility has extra empty beds, RN M stated they did. When asked why Resident #43 was not transferred into an empty, functioning bed rather than being left in a position which was causing them pain, RN M revealed they were unable to provide an explanation. On 1/9/25 at 8:18 AM, Maintenance Director L entered Resident #43's room. When asked what was wrong with the Resident's bed, Director L stated, Controller came unplugged. When asked, Director L pointed out the previously noted disconnected cord and plug box located on the lower right underside of the bed. Director L plugged the cord into the connection and the bed was noted to work. Director L lowered the head of Resident #43's bed and the Resident verbalized increased comfort. An interview was completed with Director L on 1/9/25 at 8:23 AM after exiting Resident #43's room. When queried why staff did not check the cord to ensure it was connected, Director L was unable to provide an explanation. When asked if nursing staff could have plugged the cord into the bed to be able to reposition the Resident, Director L replied, Yeah they could have. An interview was conducted with the Director of Nursing (DON) on 1/9/25 at 10:23 AM. When queried regarding Resident #43's malfunctioning bed, the DON revealed they were aware. The DON was informed of CNA K stating they were unable to provide incontinence care because of the bed being broken and that incontinence care had not been provided since night shift. The DON specified they would look into it. When queried regarding Resident #43 complaining of pain and the staff exiting their room without attempting to reposition the Resident and/or provide comfort, the DON stated, I have nothing to say. I can't. On 1/9/25 at 12:04 PM, a follow up interview was completed with the DON. The DON verbalized they spoke to Resident #43's assigned CNA during the prior night shift. The DON stated, (CNA O) told me the last time the bed worked was at 2:00 AM and they changed (Resident #43) about 4:00 AM. When queried how they changed Resident #43 when they were dependent and the head of their bed was elevated at 60 degrees, the DON responded -that they used three to four people. When queried regarding the concern of staff not addressing the malfunctioning bed and pain as well as providing incontinence care, the DON confirmed the concern. No further explanation was provided. Record review revealed Resident #43 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included cerebral infarction (stroke), pain, anxiety, bipolar disorder, tracheostomy (surgically created opening in the throat to allow air to pass into the lungs), and respiratory failure with ventilator (machine which supports and/or breaths for an individual when they are unable) dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required maximum to total staff assistance to complete ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #43's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an ADL self-care performance deficit related to Respiratory failure and on vent (ventilator) via trach (tracheostomy) . Readmit 12/19/24 following an acute hospital stay possible aspiration PNA (pneumonia) . (Initiated: 7/19/23; Revised: 12/20/24). The care plan included the interventions: - Bed Mobility: The resident requires dependent care of 2 with bed mobility (Initiated: 7/19/23; Revised: 5/21/24) - Toileting . resident requires total assist of 2 person assist with toileting (Initiated: 7/19/23; Revised: 7/10/24) - Transfers . 2-person assist AND use of mechanical lift (Initiated and Revised: 5/14/24) Resident #61: On 1/8/25 at 12:04 PM, Resident #61 was observed in their room laying in in bed with their eyes open wearing a hospital style gown. Resident #61 was receiving mechanical ventilation via a tracheostomy. When spoke to, Resident #61 responded by mouthing words without making sound. Resident #61 had a cell phone on their bed. When asked if they were able to write and/or type, Resident #61 indicated they could. When queried regarding staff responsiveness to call lights, Resident #61 responded, Long time to answer call lights. Resident #61 then stated, It takes them too long. With further inquiry regarding call light wait times, Resident #61 responded, It depends on who's working. Some are really good and others not so much. Resident #61 revealed staff will enter their room and turn off their call light without addressing their needs, and not return to help them. A bedside commode was observed in the Resident's room. The commode had items sitting on top of the closed seat and appeared unused. When asked if they used the commode, Resident #61 revealed they had only used the commode once. When asked if they knew when they needed to use the restroom, Resident #61 confirmed they did. Resident #61 then revealed that due to being dependent upon the ventilator, they require assistance to get out of bed and to use the restroom. Resident #61 revealed they put on their call light when they need to use the restroom, but the staff do not respond in time to assist them to the toilet. When queried if they were saying they had accidents (incontinence) due to lack of timely assistance by staff, Resident #61 shook their head to indicate yes. Resident #61 was then asked how that makes them feel and revealed they felt embarrassed. Resident #61 conveyed further feelings of frustration. Record review revealed Resident #61 was admitted to the facility on [DATE] with diagnoses with included dysphagia (difficulty swallowing), anxiety, end stage renal disease with dialysis dependance, aphonia (loss of voice), tracheostomy, and respiratory failure with ventilator dependance. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, had unclear speech, and required maximum to total assistance with transferring, bathing, and toileting. The MDS further revealed the Resident was frequently incontinent of bowel and bladder and was not on a toileting program. Review of Resident #61's EMR revealed a care plan entitled, Resident has an ADL self-care performance deficit related to presenting to ED with respiratory distress, leading to intubation and tracheostomy (3/14/24), followed by vent . (Initiated: 5/8/24; Revised: 7/30/24). The care plan included the interventions: - Resident uses a wheelchair with cushions (Initiated: 5/10/24) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Toileting: 2-person extensive assist (Initiated: 5/10/24; Revised: 8/15/24) - Transfers . 2-person extensive assist (Initiated: 5/9/24; Revised: 5/10/24) Resident #61 did not have an individual, specific care plan in place related to bowel and bladder continence. On 1/9/25 at 12:04 PM, Resident #61 detailed, It's happening right now. I turned my light on at 11:19 AM. At 11:35 AM, someone came in and went to look for my aide (Certified Nursing Assistant-CNA). Resident #61 revealed that while they were waiting for the CNA to assist them, a Respiratory Therapist had provided respiratory care but did not assist them to use the restroom. Resident #61 disclosed they put their call light on because they needed to use the restroom and they needed to be changed now. Resident #61 revealed they also wanted to get out of bed and sit in their wheelchair. On 1/9/25 at 12:30 PM, an interview was completed with Resident #61 and the Director of Nursing (DON). Resident #61 was in their room, sitting in bed wearing a hospital gown. When queried if a staff member had been in to assist them, Resident #61 revealed a CNA had just left the room. Resident #61 told the DON their concerns at this time including having to wait an hour for assistance and being incontinent due to not receiving assistance. Resident #61 further stated they were still waiting for a staff member to help them get into their wheelchair and informed the DON that they did not like sitting in bed all day. After exiting Resident #61's room, an interview was conducted with the DON. When queried regarding staff turning off Resident #61's call light, not returning, the Resident waiting an hour for staff to assist them with toileting and then being incontinent due to the wait, the DON stated, I understand why you have concerns and indicated the concerns would be addressed. 22348 Activities of Daily Living Resident #39 (R39): On 01/08/25 at 1:21 PM, R39 was observed eating his meal alone in his room. Food consist of cut up (mechanical soft) consistency. He was not assisted and was not supervised while eating his meal. R39 was ask if somebody was here to help him with his meal. He shook his head indicating no. On the walls in his room are posted swallowing precautions and instruction on what to watch for. R39 was asked if he has difficulty swallowing. He stated yes and noded his head. R39 did not wear clothing protector and was observed with food all over his chest and his bed. Because of the swallow precaution signs up on the wall, the surveyor went out of R39's room to look for any staff to assist and verify R39 status while eating. No staff was found in 600 hall at that time. On 1/9/25 at 9:55 AM an Interviewed Nurse C was conducted. Nurse C indicated that R39 is currently level 3 texture with honey liquid. He is supervision during meals while eating and offer assistance setting up and cutting up the food. When Nurse C was asked to explain what supervision meant for Level 3 she briefly stated, someone has to be present while he eats. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at10:00 AM, an interview with RD E was conducted. RD E indicated that his diet is a Level 3 diet with flushing, and honey thickened fluid. R39's current careplan is supervision with meals and someone has to monitor, assist as needed and set up with R39's meals. He is in swallowing precaution. RD E stated I am not sure why R39 did not have a clothing protector. On 1/9/25 at 2:30 PM a review of record was conducted. According to the Electronic Medical Record, R39 was [AGE] years old with current admitted [DATE]. R39 had a diagnosis of Hemiplegia and Hemiparesis from a Stroke affecting his left dominant side, dysphagia, and generalized muscle weakness in addition to other diagnoses. His BIMS (Brief Interview of Mental Status) Score is 15/15 assessment date of 10/24/24. R39 had a careplan initiated on 7/18/2024, for Activities of Daily Living (ADL) self-care performance deficit related to history of CVA with left sided weakness and other contributory diagnoses. A Care Plan intervention for eating revealed, Supervision- offer assistance with meal set up as needed, fluid flush as ordered via peg. Date intiated was 7/22/24 and revised date was 12/2/24.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 38471 Based on interview and record review the facility failed to curate an activities program that met the interest and needs of the facility residents, resulting in, activity programming being monotonous and lacking originality. With nine residents from resident council expressing feelings of frustrations, discontentment, and unimportance. Findings include: During Resident Council on 1/9/2025 at 1:45 PM, the nine residents in attendance were queried regarding the facility activity programming. The overarching tone of the group was they would enjoy a wider variety of activities that was of interest to residents that are cognitively intact. They shared the rarely attended resident council as they did not feel comfortable sharing their concerns as they were not confident they would be addressed. They were unanimous with the following areas of concern for the activity program as well: -Many of the programs are boring, and they have no interest in attending them. They provided an example of decorating the ashtray the day prior. -The activities are not well organized which causes undue frustration. -Only one resident attends karaoke and they are uncertain as to why it is still on the calendar when it's obvious the majority is not interested. -They expressed confusion on why they attempted to move BINGO to the morning. -BINGO prizes are catered toward the women in the facility (i.e. jewelry, headbands) and once the first few people pick their prizes there is not much substantial items for them to choose from. -The programming is repetitive each month -Many of the specialty activities are for women and not of interest to the men in the facility so they would prefer not to come. -There is not enough space for specialty wheelchairs on the bus so many times it's the same residents that are attending the outing. The residents shared they want a fulfilling activities program that is inclusive of all facility residents and currently they feel the program is ineffective in meeting the classes of residents within the facility. Review was completed of Resident Council Notes from April 2024- December 2024 and in that nine month period the following occurred: -4 months only 1 resident attended resident council meetings (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1 month only two residents attended resident council meetings -1 month no resident attended resident council meetings Review was completed of the facility's Activity Calendars from July 2024- January 2025. It was evident the programming lacked originality and did not utilize residents' interests to create events they would want to attend. All Sundays from July 2024- January 2025 are the same events: -10:30 AM: Religious Activity/Devotionals -2:00 PM: Extra -3:00 PM: BINGO Mondays: -Of the 31 Mondays from July 2024 - January 2025 there 19 Mondays where the scheduled activities were the identical. Review was completed of each month (July 2024- December 2024) of activity calendars and it was found most weeks with the exception of some specialty programs) are scheduled with minimum aberration from one another. July 2024 Calendar: Tuesdays: 10:30 AM- Listen and Learn 11:00 AM- Craft or question and answer 2:30 PM- BINGO 4:00 PM- Rocking Room Visits 7:00 PM - Tuesday Manicures Fridays: 10:30 AM- Coffee Talk 1:30 AM- Rocking Room Visits 3:00 PM: Resident choice/ Karaoke 7:00 PM: Games (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saturdays: 10:30 AM: Saturday Morning Mingle 2:30 PM: Movies and Manicures August 2024: Tuesdays: 10:30 AM: Listen and Learn 11:00 AM: Crafts 2:30 PM: BINGO 4:00 PM: Rocking Room Visits 7:00 PM: Tuesday Manicures Wednesdays: 10:30 AM: Daily Chronicles 11:00 AM: Thoughtful Time 1:30 PM: Rocking Room Visits Fridays: 10:30 AM: Coffee Talk 1:30 PM: Rocking Room Visits 2:30/3:00 PM: Karaoke or Resident Choice 7:00 PM: Games Saturdays: 10:30 AM: Saturday Morning Mingle 2:30 PM: Movies and Manicures September 2024: Fridays: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:30 AM: Coffee Talk 1:30 PM: Rockin Room Visits 3:00 PM: Karaoke Fun 7:00 PM: Games Saturdays: 10:30 AM: Saturday and Morning Mingle 2:30 PM: Movie and Manicures October 2024: Wednesdays: 10:30 AM: Daily Chronicles 1:30 PM: Rockin Room Visits 7:00 PM: Game/ Coloring Saturdays: 10:30 AM: Saturday Morning Mingle 2:30 PM: Movie and Manicures November 2024: Tuesdays: 10:30 AM: Listen and Learn 2:30 PM: BINGO 4:00 PM: Rocking Room Visits 7:00 PM: Tuesdays Manicures Thursdays: 1:30 PM: Rocking Room Visits 2:30 PM: BINGO (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7:00 PM: Music Jam Saturdays: 10:30 AM: Saturday Morning Mingle 2:30 PM: Movies and Manicure or Movies and Popcorn December 2024: Tuesdays: 10:30 AM: Listen and Learn 2:30 PM: Crafts 2:30 PM: BINGO 4:00 PM: Rockin Room Visits 7:00 PM: Tuesday Manicures Saturdays: 10:30 AM: Saturday Morning Mingle 2:30 PM: Movies and Manicures On 1/10/2025 at 11:50 AM, an interview was conducted with Activities Director U regarding the facility programming and the concerns garnered from resident council. Director U reported she builds out the activity calendar herself and utilizes activity connection for ideas. When asked if the calendar is repetitive per month, she shared she does copy and paste the activities from month to months so their may not be much variation. When asked why she did not cater her programming to her residents more versus copy and pasting her calendar each month, she did not have a response. Director U was asked how many residents participate in Karaoke, she responded, one. She was asked if only one resident attended, why that would still be an activity that carried for multiple months on her calendar. Director U did not have a substantial answer. Director U reported they have one outing per month and when queried regarding how many residents the bus can hold, she explained it holds about eight ambulatory residents and two standard wheelchairs. It a resident with a specialty wheelchair wanted to attend only one could go given the sizing of the bus. Each month her staff ask the residents who wants to go but it is the same residents that typically go. When asked if they would be able to accommodate three residents with specialty chairs she stated they would not. Director U was queried if it was ever considered adding two of the same outings to ensure residents that are interested are not discouraged and she stated she had not. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was shared with the Director the concerns regarding the lack of variety of BINGO store prizes. Director U reported the store does have more items that are geared toward women which she has noticed and had tried to increase items for the men in the facility. When asked if she had taken a list of items her residents wanted/needed to place in the BINGO store she stated she had not. Review was completed of the facility policy entitled, Activities, revised 10/30/2023. The policy stated, .Facility sponsored group and individual activities, and independent activities will be designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community .Activities will be designed with the intent to: a. Enhance the residents sense of well-being, belonging and usefulness; b. Promote or enhance physical activity; c. Promote or enhance cognition; d. Promote or enhance emotional health; e. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence; f. Reflect resident's interests and age; g. Reflect cultural and religious interest of the residents; h. Reflect choices of the residents . Review was conducted of the Activity Director job description and it stated, Through comprehensive assessment and evaluation, develops program of activity therapy from a holistic approach to meet the needs of a diverse resident population .Based on findings develops an individualized program of activity pursuits that are meaningful to the resident . Develops and maintains community volunteer efforts .

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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** 37771 Based on interview and record review, the facility failed to treat a change in condition timely for one resident (Resident #30) of one resident reviewed for delay in treatment, resulting in the potential for exacerbation of signs and symptoms of pneumonia, sepsis, extended illness and wellbeing. Findings include: Resident #30: A review of Resident #30's medical record revealed an admission into the facility on [DATE] and readmission on 5/2/24 with diagnoses that included chronic obstructive pulmonary disease, influenza, and sepsis. A review of Resident #30's medical record of progress notes revealed the following: 12/29/24 at 6:54 PM, Progress Notes, Note Text: pt (patient) had c/o (complaints of) cough and chills this evening I took pt temp. it was 98. I did a Covid and influenza test they all came back negative. Pt requested cough syrup for his cough on on-call messaged and gave order for prn (as needed) cough syrup QID (four times a day). I put in house stock cough syrup and gave it to the pt. 12/31/2024 at 1:11 PM, Pertinent Charting-Change in Condition, Note Text: Event Date: 12/30/2024; Change identified: Resident has a cough and has a temp. (temperature); Assessment: Resident lung sounds indicate wheezing. Resident is coughing and is running a high than normal temp. Nursing intervention: Chest x-ray ordered. MD Notification: Yes . 12/31/2024 at 1:13 AM, Nurses' Notes, Note Text: coming onto shift previous nurse reported resident had a high temperature reading Tylenol given to help decrease the temperature also reported that resident has had a cough for a couple of days chest x ray done previous shift waiting on results. Resident also had a high temperature reading this shift resident stated Covid test was taken yesterday negative. Cough continues, wheezing heard upon auscultation in bother upper lobes. Prn (as needed) breathing treatment given this shift as well as cough medication temperature did go back to normal within a hour after medication given on call notified. 1/1/25 at 3:19 AM, Nurses Notes, Note Text: coming onto shift on call was notified that residents chest results were in. Fax copy over 3-4 more times on call stated she was unable to see results from her end refax 4-5 more times on call states she still did not get faxed typed out findings and impression on chat easy current waiting on new orders. Resident continues to complain of SOB (shortness of breath), cough present wheezing in upper lobes. PRN cough medication as well as breathing treatment administered this shift. 1/1/25 at 3:07 PM, Pertinent Charting-Change in Condition, Note Text: Event Date: 1/1/2025, Originally identified change: Cough Resident retested for Covid this shift negative results. Resident being tested for RSV, sample sent collected this shift. Prn cough medication given this shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/1/25 at 9:21 PM, Nurses Notes, Note Text: RSV Vikor testing ordered by (physician group) NP (nurse practitioner) . 1/1/25, Provider Note by Physician W, .Lobar pneumonia, unspecified organism: We will start patient on Levaquin at this time currently he is stable does not require isolation. 1/2/25 at 10:21 AM, Order Note, Note Text: The system has identified a possible drug allergy for the following order: Zithromax Oral tablet 500 mg (Azithromycin) Give 1 tablet by mouth one time a day for Pnemonia until 1/9/25 . 1/5/2025 10:07 AM, Orders - General Note from eRecord, Note Text: resident asking about antibiotic ordered by dr (doctor) 2-3 days ago. looked at provider notes and (Practitioner name) ordered levaquin 500mg 1 per day x 7 days for pneumonia. no order in system. placing order today. 1/6/25, Practitioner Progress Note, .Follow up respiratory status and doxycycline ordered. Recent CXR (chest x-ray) reviewed Lobar pneumonia, unspecified organism: Levaquin changed to doxycycline due to allergy to quinolone . A review of Resident #30's medical record revealed the following respiratory testing: -Respira-ID Molecular Pathogen Report-collection on 1/1/25, report date 1/4/25, Pathogens Detected included Staphylococcus aureus and Influenza virus. The fax information at the top of the documents indicated the fax was sent to the facility on the 4th at 10:07 AM. The bottom of the report indicated report date on 1/4/25 and printed at 10:06 am. A review of Resident #30's Medication Administration Record for January 2025 revealed an order for Levaquin Tablet 500 MG (milligrams). Give 1 tablet by mouth one time a day for Pneumonia for 7 days with a start date on 1/3/25 and discontinued date on 1/5/25. The medication was documented as not given with a 9 that indicated Other/see Progress Notes. The Administration notes on 1/3/25 and 1/4/25 revealed, Awaiting arrival from pharmacy, and on 1/5/25 Guest has an allergy to medication, awaiting an order for a replacement med. (medication) On 1/10/25 at 12:14 PM, an interview was conducted with the Infection Control Preventionist/Assistant Director of Nursing (ICP) Nurse N and the DON. A review of the onset of Resident #30's signs and symptoms revealed the Resident had a cough that started on 12/29/24 and temperatures on 12/29 at 8:54 pm of 101.4, 12/30 at 9:26 am of 102.1 and on 12/30 at 8:57 pm of 101.7 degrees Fahrenheit, as identified by the ICP who was reviewing Resident #30's medical records. The ICP indicated that the facility had tested for Covid-19 and Influenza rapid test that were negative. The ICP indicated that a respiratory panel was sent out for Resident #30 on 1/1/25 and resulted on 1/4/25 for being positive for influenza and was had Staphylococcus aureus pathogen detected. The ICP reported not being aware of the laboratory results until coming into the facility on [DATE]. The ICP indicated the fax was sent to the facility on [DATE] with the positive results and had not been seen by facility staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review with the DON and ICP of the Practitioner did not put in the order for the Levaquin when seen on 1/1/25, on 1/2/25 an order for Zithromax was put in but the Resident had an allergy and on 1/2/25 an order for Levaquin was put in. The Levaquin was to start on 1/3 but was not given. The DON indicated that the Resident had an allergy, and the medication was changed to Doxycycline. The DON was asked why it took three days to get that information and get another antibiotic ordered. The DON stated, I don't know, that's a good question. The DON indicated that the pharmacy would have sent an email and they called. When asked who they called and emailed, the DON indicated that on 1/6 the Practitioner had changed the antibiotic to Doxycycline. It was reviewed with the DON and ICP of the concern with a delay in treatment for pneumonia for Resident #30, and a delay in getting laboratory results from the fax machine timely. The DON stated, Ideally they should get the fax and then call the physician.

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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** 37771 Based on observation, interview and record review, the facility failed to enact care-planned interventions for safety/monitoring/supervision for Residents (#4, 35 and 39) of 9 reviewed for accident hazards and feeding assistance, resulting in the potential for injury for Resident #4 transferred with a mechanical lift with one staff assist, fall with injury for Resident #35 who did not have a call light within reach and a fall mat placed at the bedside, and the potential for choking or aspiration of food for Resident #39. Findings include: Resident #4: A review of Resident #4's medical record revealed an admission on 7/1/20 and readmission on 11/9/21 with diagnoses that included multiple sclerosis (MS), dementia, muscle wasting and atrophy and Alzheimer's disease. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 9/15 that indicated moderately impaired cognition, and the resident was dependent with most activities of daily living and transfers. On 1/10/25 at 4:02 PM, an observation was made of Resident #4's door open about a foot wide. An observation was made from the hallway of the Resident getting transferred into a shower chair by a mechanical lift and being placed into a shower bed. The Resident was not dress-ed in a gown or had clothing on. The resident could be visualized from the hallway. The surveyor entered the room. An observation was made of Resident #4's room and one CNA. The CNA was asked about transferring the Resident by herself. CNA J indicated that she had transferred the Resident herself, that she was behind in her work and trying to get caught up. The CNA was asked about facility policy and why she did not have two staff members to transfer the Resident. The CNA stated, Everyone is everywhere, and indicated other staff were not available to assist. The CNA indicated she had cleaned her up prior to the transfer with the mechanical lift. A review of Resident #4's care plan revealed a focus Resident has an ADL (activities of daily living) self-care performance deficit related to dx (diagnoses) of progressing MS, muscle weakness, muscle wasting, loss of functional mobility and Alzheimer's dementia. The interventions included Bed Mobility: 2 person total assist, with revision done on 7/24/24 and Transfers: 2 person total assist with Hoyer lift ., revision on 12/18/23. On 1/14/25 at 2:39 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) N regarding Resident #4 transferred by a mechanical lift with one person assist. The ADON indicated a Hoyer lift transfer should be two staff assisting in the transfer and the DON indicated they will follow up on the incident. Resident #35 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #35's medical record revealed an admission into the facility on [DATE] with diagnoses that included encephalopathy, multiple sclerosis, seizures, history of benign neoplasm of the brain, lack of expected normal physiological development in childhood, muscle wasting and atrophy, and hemiplegia affecting left nondominant side. A review of Resident #35's MDS revealed a BIMS score of 3/15 that indicated severely impaired cognition, and the Resident needed substantial/maximal assistance with eating and was dependent on staff for other activities of daily living and most transfers. On 1/8/24 at 2:23 PM, an observation was made of Resident #35 in bed with the head of the bed elevated. The resident was interviewed, answered some questions and was limited with responses. The Resident had bilateral floor mats to either side of the bed. The Resident had a cup with orange juice and was trying multiple times to pick the cup up. The Resident was leaning at a slightly odd angle. The Resident asked the surveyor to help her sit up better so she could drink her orange juice. The Resident was asked where her call light was and stated she did not know where to find it. An observation was made of the call light laying on the floor near the head of the bed. The Resident was asked if they keep the call light in reach for her and the Resident stated, It falls a lot. An observation was made of no visible clip on the cord and the Resident stated, That would help. The Resident asked for assistance again and staff was summoned to the room and notified of the call light on the floor. On 1/10/24 at 3:50 PM, an observation was made of Resident #35 laying in bed. There was one fall mat on the residents left side. The fall mat on the right-hand side was not in place. On 1/14/24 at 10:00 am, a review of progress notes revealed the following: -Dated 11/29/24 at 11:17 AM, Interdisciplinary Progress Note, On 11/28 at 2135 (9:35 PM), nurse observed resident sliding off the side of bed to the floor. Bed was noted to be in lowest position. When asked what happened, resident stated she didn't do it and is sorry and won't do it again. Resident was immediately assessed. No pain or injury noted . Root cause: Resident is a new admission to facility. Staff witnessed resident purposefully lowering herself from bed to floor. Intervention: Bilateral floor mats placed next to bed . On 1/14/24 at 10:00 AM, a review of Resident #35's care plan revealed the following: -Focus: Resident is at risk for falls/injury related to bladder incontinence, bowel incontinence, decreased strength and endurance, generalized weakness, hemiplegia, impaired cognition with decreased safety awareness, needs assistance with ADL's, recent surgery, date initiated 11/27/24. -Interventions included: Bilateral Floor Mat placed next to bed, date initiated 11/29/24; Encourage resident to use call light, date initiated 11/28/24; and Place call light within reach, date initiated: 11/27/24. -Focus: Resident has an ADL self-care performance deficit related to . -Interventions included: Eating: extensive 1 person assistance with meal, revision on 11/29/24; Encourage resident to use call light when assistance is needed, date initiated 11/28/24; and Place call light within reach, date initiated 11/27/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility policy titled, Falls-Clinical Protocol, reviewed/revised 11/2/23, revealed, Policy Explanation and Compliance Guidelines: 1. As part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling . 2. Based on the assessment an initial plan of care will be developed and implemented to address identified risk. This will be revised as necessary . 5. Interventions should be developed and implemented per the assessed needs. Additional items to remember when developing the plan of care include: Resident's abilities and deficits, Balance [sitting/standing], Adaptive equipment needs, Proper use of mechanical lifts and transfer devices . 22348 FACILITY Dining Observation On 01/08/25 at 1:21 PM, R39 was observed eating his meal alone in his room. Food consist of cut up (mechanical soft) consistency. He was not assisted and was not supervised while eating his meal. R39 was ask if somebody was here to help him with his meal. He shook his head indicating no. On the walls in his room are posted swallowing precautions and instruction on what to watch for. R39 was asked if he has difficulty swallowing. He stated yes and nodded his head. R39 did not wear clothing protector and was observed with food all over his chest. Because of the swallow precaution signs up on the wall, the surveyor went out of R39's room to look for any staff to assist and verify R39 status while eating. No staff was found in 600 hall at that time. A review of the Electronic Medical Record conducted on 1/9/25 at 2:30 PM, revealed that R39 was [AGE] years old with current admitted [DATE]. R39 had a diagnosis of Hemiplegia and Hemiparesis from a Stroke affecting his left dominant side, dysphagia, and generalized muscle weakness in addition to other diagnoses. His BIMS (Brief Interview of Mental Status) Score is 15/15 assessment date of 10/24/24. R39 had a careplan initiated on 7/18/2024, for Activities of Daily Living (ADL) self-care performance deficit related to history of CVA with left sided weakness and other contributory diagnoses. A Care Plan intervention for eating revealed, Supervision- offer assistance with meal set up as needed, fluid flush as ordered via peg. Date initiated was 7/22/24 and revised date was 12/2/24. On 1/9/25 at 9:55 AM an Interviewed Nurse C was conducted. Nurse C indicated he is a peg tube for his medication and was upgraded to eating food orally. R39 has peg tube used for medication administration. R39 started eating food by mouth in pureed consistency initially and is currently level 3 texture with honey liquid. He is supervision during meals while eating and offer assistance setting up and cutting up the food. When Nurse C was asked to explain what supervision meant for Level 3 she briefly stated, someone has to be present while he eats. On 1/9/25 at 10:00 AM, an interview with RD E was conducted. RD E indicated that his diet is a Level 3 diet with flushing, and honey thickened fluid. R39's current careplan is supervision with meals and someone has to monitor, assist as needed and set up with R39's meals. He is in swallowing precaution. RD E stated I am not sure why R39 did not have a clothing protector.

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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** 38471 Based on observation, interview and record review the facility failed to provide catheter care in accordance with current clinical standards for one (#50) resident of 1 resident reviewed for catheters, resulting in, Resident #50 returning from the emergency room with a urinary catheter unbeknownst to the facility and without proper assessment, monitoring and ongoing care. Findings Include: Resident #50: During initial tour on 1/8/2025, Resident #50 was observed in bed conversing with his wife. Observed hanging on the bed frame was a catheter drainage bag that was partially full of urine. Resident #50 explained he recently was evaluated at the emergency room , and they placed a catheter. On 1/8/2024 at approximately 3:45 PM, a review was completed of Resident #50's medical record and it indicated he admitted to the facility on [DATE] with diagnoses that included, Fracture of left tibia shaft, left fibula shaft, right and left patella, right talus, epilepsy, heart disease and dysphagia. Resident #50 is dependent on staff for his daily cares but is cognitively intact. Further review of his record indicated the following: Progress Notes: 12/30/2024 at 12:23: Unit Manager spoke with resident. He states that Ortho is the only one who can help him with his knees .He states that going into ER would be the last resort. UM called (Ortho) on 12/30/24 and will follow up with them, if I do not hear back from them, UM informed the resident that a call was placed by the UM on 12/30/24. 12/30/2024 at 13:15: UM received return phone call from (Ortho). She will ask the providers for an order to follow up with ortho., the resident insists on going out to the ER. 12/30/2024 at 23:18: Resident was sent out to the hospital previous shift will not return this shift. There were no progress notes regarding Resident #50's return from the emergency room Return from Leave Assessment: Completed 1/1/2025 at 1:40 AM did not denote a catheter. Care Plan: There is no mention of urinary catheter in Resident #50's care plan (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/2025 at 11:20 AM, Resident #50 was observed resting in bed and his drainage bag was not hanging on the side of the bed frame. When asked about it, he was not able to tell this writer when it was removed. Review was completed of his progress notes and there was no documentation located of when the urinary catheter was removed. On 1/10/2025 at 11:25 AM, CNA (Certified Nursing Assistant) A reported he was assigned to provide care to Resident #50 earlier in the week and he did have a catheter. CNA recalled emptying the drainage bag and providing catheter care during his shift as needed. The CNA was asked if the charting prompts for Resident #50 indicated he had a catheter and he started there was no charting for Resident #50 related to his urinary catheter. On 1/10/2025 at 11:30 AM, Unit Manager B was asked who removed Resident #50's catheter. The Unit Manager stated he was unaware the resident had one presently, it was explained it was placed at the emergency room but there was no documentation found upon his return. Unit Manager B stated he would investigate and follow up. On 1/10/2025 at approximately 12:15 PM, Unit Manager B reported he was unable to find any additional information related to this. He stated if/when a resident returns with a urinary catheter the proper orders for monitoring, assessment of, cleaning, changing/emptying the bag etc. would need to be entered. A secondary review was conducted of Resident #50's medical record and there was no indication that he returned from the emergency room with a urinary catheter. There were no physician orders, nursing notes, assessment or associated care plan. Review was completed of the facility policy entitled, Catheter Care Procedure - Urinary revised 10/30/2020. The policy stated, .Residents with urinary catheters will be provided with catheter care in accordance with current clinical standards. This may include: a. Every shift .Catheters should be emptied every shift or as needed. Urinary output should be recorded per facility protocol.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure enteral tube feeding (liquid nourishment provided directly into the stomach through a feeding tube) administration was per Health Care Provider orders and professional standards of practice for one resident (#55) of three Residents reviewed, resulting insufficient head of bed elevation during tube feeding administration and the potential for aspiration, infection, and decline in overall health. Findings include: Resident #55: On 1/9/25 at 8:31 AM, Resident #55 was observed in their room in bed, positioned on their back. Resident #55 was receiving mechanical ventilation via a tracheostomy and tube feeding via pump. The Head of the Resident's bed at a 24-degree angle per the measurement device on the bed and correlated with a angle measurement device. When spoke to, Resident #55 did not make eye contact and did not provide a verbal response. Record review revealed Resident #55 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included gastrostomy (surgically placed tube into the stomach through the abdominal wall for the introduction of nutrition), end stage renal disease with dialysis dependence, heart disease, tracheostomy (surgically created opening in the throat to allow air to pass into the lungs), and respiratory failure with ventilator (machine which supports and/or breaths for an individual when they are unable) dependence, and pneumonia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required maximum to total assistance to complete Activities of Daily Living (ADL's). A review of Resident #55's care plans and Health Care Provider (HCP) orders revealed the Resident did not have a care plan and/or order which specified the degree of head elevation during tube feeding administration. An interview was completed with the Director of Nursing (DON) on 1/14/25 at 12:50 PM. The DON was asked if the head of the bed should be elevated when a Resident is receiving tube feeding and stated, Yes, at a minimum of 30 degrees. The DON was informed of observation of Resident #55 receiving tube feeding when the head of their bed was at 24-degrees and reiterated it should have been at 30 degrees minimum. The DON confirmed and verbalized understanding of the concern. No further explanation was provided. Review of facility policy/procedure entitled, Feeding Tubes (Revised: 10/15/24) did not specify head of bed elevation during tube feeding administration. According to [NAME] (2022), The head of the bed should be elevated 30-45 degrees during enteral feeding (p. 11). Reference: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[NAME] J. (2022). Enteral Nutrition Overview. Nutrients, 14(11), 2180. https://doi.org/10.3390/nu14112180

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for management and care of a Peripherally Inserted Central Catheter (catheter line inserted into the arm and extends to the heart for long term administration of intravenous [IV] medications- PICC) line for one (#280) of one Resident reviewed resulting in a PICC line not being flushed following medication administration and the potential for malfunction, occlusion, blood clot formation, and infection. Findings include: Resident #280: On 1/9/25 at 8:49 AM, Resident #280 was observed laying in their bed in their room. Registered Nurse (RN) P was present in the room. When asked, RN P revealed they had just finished administering the Resident's medications. Resident #280 made eye contact when spoke to but did not provide verbal or meaningful non-verbal responses to questions. An IV pump was in place on the left side of the bed. The pump was turned off with an empty bag of IV Cefepime (antibiotic commonly used to treat pneumonia) hanging on the IV pole with primary IV tubing. The Cefepime IV tubing was connected to the PICC line in Resident #280's left upper arm. The PICC line dressing was dated as being changed on 1/8 at 1100 (AM). RN P was queried regarding the IV antibiotic and stated, It's still hanging from midnight shift. When asked if PICC lines are supposed to be flushed following medication administration and use, RN P responded that PICC's should be flushed and indicated they would flush the PICC. Immediately after exiting Resident #280's room, a review of Resident #280's Medication Administration Record (MAR) was completed with RN P. Review of the MAR revealed last dose of IV Cefepime was administered on 1/8/25 at 5:15 PM. When queried why the IV antibiotic had not been flushed following infusion completion, RN P was unable to provide an explanation. Further review of the MAR revealed the location of the PICC line was documented at left upper extremity for all administrations from 1/4/25 to 1/8/25 with the exception of being documented as the right upper arm on 1/8/25 at 6:12 AM and 12:17 PM. Record review revealed Resident #280 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Amyotrophic Lateral Sclerosis (ALS- terminal neurodegenerative disorder which causes progressive weakness and loss of muscle control), anarthria (inability to speak), tracheostomy (surgically created opening in the throat to allow air to pass into the lungs), and respiratory failure with ventilator (machine which supports and/or breaths for an individual when they are unable) dependence, and pneumonia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and was dependent upon staff for completion of all Activities of Daily Living (ADL's). Review of Resident #280's Electronic Medical Record (EMR) revealed the Resident did not have a care plan in place for PICC line monitoring and care. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 1/9/25 at 10:23 AM. When queried if PICC lines are supposed to be flushed following IV medication administration, the DON replied, Should be. The DON was informed of observations of Resident #280's IV Cefepime bad and tubing from administration on 1/8/25 at 5:15 PM still hanging and being connected to the PICC line on 1/9/25 at 8:49 AM as well as RN P's statements. The DON then stated, I understand your concern on that. Upon request for a facility policy/procedure related to PICC line flushing, maintenance, and care, the DON provided a policy entitled, Flushing Guidelines for Peripheral Venous Catheter (Revised 2/19). Review of this policy revealed, General Guidelines . IV catheter will be flushed prior to each infusion . and after each infusion .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on interview and record review, the facility failed to acquire medication timely from pharmacy services or obtain from back-up medication storage for one resident (Resident #45), of seven reesidents reviewed for medication regimen review, resulting in medication Bumetanide and Spironolactone not administered as ordered and the potential of exacerbation of medical conditions. Findings include: Resident #45: A review of Resident #45's medical record revealed an admission into the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, diabetes, dependence on supplemental oxygen, atherosclerotic heart disease, and acute kidney failure. A review of medication orders for Resident #45 revealed the following: Bumetanide 1 mg (milligram). Give 1 tablet by mouth one time a day for fluid retention related to chronic obstructive pulmonary disease, with a start date on 7/23/24 and discontinued on 1/6/24. Bumetanide 1 mg. Give 1 tablet by mouth two times a day for fluid retention, ordered on 1/5/24. Spironolactone 25 mg. Give 1 tablet by mouth one time a day related to unspecified systolic (congestive) heart failure, with a start date on 7/23/24. A review of Resident #45's Medication Administration Record (MAR) revealed that the Resident was not administered Bumetanide on 12/22, 12/23, 12/25, 12/26, 12/27 and 12/31. The progress notes of Orders-Administration Notes, revealed the following: 12/22/24, Bumetanide, waiting on medication from pharmacy. 12/23/24, Bumetanide, on order from pharmacy 12/25/24, Bumetanide, waiting on medication from pharmacy. 12/26/24, Bumetanide, waiting on medication from pharmacy. 12/27/24, Bumetanide, awaiting from pharmacy. 12/31/24, Bumetanide, waiting on medication from pharmacy. A review of Resident #45's Medication Administration Record (MAR) revealed that the Resident was not administered Spironolactone on 12/23, 12/25, 12/26, 12/27, 12/28, 12/29. The progress notes of Orders-Administration Notes, revealed the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/23/24, Spironolactone, On order from pharmacy 12/25/24, Spironolactone, Waiting on meds from pharmacy. 12/26/24, Spironolactone, Waiting on med from pharmacy 12/27/24, Spironolactone, on order from pharmacy 12/28/24, Spironolactone, on order 12/29/24, Spironolactone, on order 12/29/24, Progress Note-General, pt's spironolactone 25 mg will be sent in tonight's shipment according to (Name) at the pharmacy. 12/30/24, Spironolactone, on order. On the MAR this administration was documented as given but the note indicated that the medication was on order. Further review of the medical record revealed no practitioner progress note regarding the increase in the medication Bumetanide. There was no documentation that the practitioner had been notified that the Spironolactone and the Bumetanide had not been administered on the days listed above. On 1/10/25 at 1:01 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) N regarding the medications Bumetanide and Spironolactone not administered. Review of the MAR confirmed the lack of administration of the medications. The DON and the ADON indicated they were not aware of the problem. The DON indicated they must have run out of the medication, and it was too soon for the automatic refill, but indicated there was no communication about if it was too soon to order. The DON reported that on the first missed medication of Bumetanide, the Nurse should have contacted the provider and follow orders, switching or giving something in backup until the medication arrives. When asked how soon from pharmacy medication should be delivered, the DON indicated less than 24 hours and stated, less than 8 hours turn around. It should be here in 8 hours period without issues . and reported if it was in back up, then pull from back up and contact pharmacy for follow up. A review of the back-up medication list provided by the facility revealed that Spironolactone was available in the back-up medication. The DON indicated that if the medication was available in the back-up, then the Nurse should be getting the medication from there and call pharmacy to see about ordering the medication. On 1/14/25 a facility policy for medication administration and the acquisition of medication was requested but not received prior to the exit of the survey.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on interview and record review, the facility failed to administer medication as ordered by the practitioner for one resident (Resident #45) of seven residents reviewed for medication administration, resulting in Resident #45 not receiving the medication Bumetanide (a diuretic often used to reduce extra fluid in the body caused by conditions such as heart failure, liver disease, and kidney disease) and the medication Spironolactone (a diuretic often used to treat heart failure and high blood pressure), the residents need to have increased dosage of the medication Bumetanide and the potential for exacerbation of medical conditions. Findings include: Resident #45: A review of Resident #45's medical record revealed an admission into the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, diabetes, dependence on supplemental oxygen, atherosclerotic heart disease, and acute kidney failure. A review of medication orders for Resident #45 revealed the following: -Bumetanide 1 mg (milligram). Give 1 tablet by mouth one time a day for fluid retention related to chronic obstructive pulmonary disease, with a start date on 7/23/24 and discontinued on 1/6/24. -Bumetanide 1 mg. Give 1 tablet by mouth two times a day for fluid retention, ordered on 1/5/24. -Spironolactone 25 mg. Give 1 tablet by mouth one time a day related to unspecified systolic (congestive) heart failure, with a start date on 7/23/24. A review of Resident #45's Medication Administration Record (MAR) revealed that the Resident was not administered Bumetanide on 12/22, 12/23, 12/25, 12/26, 12/27 and 12/31. The progress notes of Orders-Administration Notes, revealed the following: 12/22/24, Bumetanide, waiting on medication from pharmacy. 12/23/24, Bumetanide, on order from pharmacy 12/25/24, Bumetanide, waiting on medication from pharmacy. 12/26/24, Bumetanide, waiting on medication from pharmacy. 12/27/24, Bumetanide, awaiting from pharmacy. 12/31/24, Bumetanide, waiting on medication from pharmacy. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #45's Medication Administration Record (MAR) revealed that the Resident was not administered Spironolactone on 12/23, 12/25, 12/26, 12/27, 12/28, 12/29. The progress notes of Orders-Administration Notes, revealed the following: 12/23/24, Spironolactone, On order from pharmacy 12/25/24, Spironolactone, Waiting on meds from pharmacy. 12/26/24, Spironolactone, Waiting on med from pharmacy 12/27/24, Spironolactone, on order from pharmacy 12/28/24, Spironolactone, on order 12/29/24, Spironolactone, on order 12/29/24, Progress Note-General, pt's spironolactone 25 mg will be sent in tonight's shipment according to (Name) at the pharmacy. 12/30/24, Spironolactone, on order. On the MAR this administration was documented as given. Further review of the medical record revealed no practitioner progress note regarding the increase in the medication Bumetanide. There was no documentation that the practitioner had been notified that the Spironolactone and the Bumetanide had not been administered on the days listed above. On 1/10/25 at 1:01 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) N regarding the medications Bumetanide and Spironolactone not administered. Review of the MAR confirmed the lack of administration of the medications. The DON and the ADON indicated they were not aware of the problem. The DON indicated they must have run out of the medication, and it was too soon for the automatic refill, but indicated there was no communication about if it was too soon to order. The DON reported that on the first missed medication of Bumetanide, the Nurse should have contacted the provider and follow orders, switching or giving something in backup until the medication arrives. When asked how soon from pharmacy medication should be delivered, the DON indicated less than 24 hours and stated, less than 8 hours turn around. It should be here in 8 hours period without issues . and reported if it was in back up, then pull from back up and contact pharmacy for follow up. The DON was asked why the Resident needed the increase in the medication Bumetanide from 1 mg daily to twice a day. The DON indicated that there was no note from the Practitioner V who wrote the order for the increase in medication. A call was placed to Practitioner V regarding the issue. The Practitioner reported the Resident had respiratory signs and symptoms and weight gain. The Practitioner was asked when medication was missed should the Nurse be contacting the Practitioner. The Practitioner indicated that the Nurse would contact them through chat easy (a text messaging system used by the facility to communicate) of a missed medication. When asked if she had received any communication in text form, the Practitioner reported she could not go back that far and look, that the messages were not available any longer. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was asked about documentation in the medical record and that the chat easy was not part of the medical record. The DON indicated they should be putting in documentation in the medical record if they had contacted the physician or talked to pharmacy. It was reviewed with the DON and ADON that the two medications were diuretic medications, not administered for multiple days with many of the days the Resident had not been administered either of the medications leading to a significant medication error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This citation pertains to Intake #MI00148741. Based on observation, interview and record review the facility failed to promptly dispose of 24 pills of oxycodone (opioid used to manage pain) and maintain accurate and legible controlled medication reconciliation records for one (#61) resident of eight resident residents reviewed for narcotic reconciliation. Findings Include: On 1/14/2025 at 1:50 PM, Vent Medication Cart 3 in the presence of Wound Care Nurse R and Nurse S. While reviewing Resident #61's Controlled Substance Log for Oxycodone IR (immediate release) 5 MG (milligram) Tab (tablet) received on 5/19/2024. The sheet was found to have rows of crossed out entries, with what appeared to be multiple witnessed initials, but they were difficult to match up to the specific row given the disorganization of the narcotic form. The form showed Resident #61 was administered an oxycodone on 1/9/2025 at 0700, but there are no nurse initials. Observation was made of the blister pack and pill bubble #11 was circled in black but no pill was in the capsule. There were 24 pills left in the blister pack which aligned with the controlled substance sheet. Review was completed of Resident #61's medical records with Wound Care Nurse R and it was found Resident #61 no longer had an order for Oxycodone as it was discontinued on 7/8/2024. Furthermore, there was no documentation found that the resident was administered the medication on 1/9/25 at 0700. The DON (Director of Nursing) reviewed the blister pack, medical record and narcotic log. They were unable to provide rationale as to why medication was administered with no order or why the blister pack was still in the medication cart after the order was discontinued. On 1/14/2025 at 2:30 PM, Vent/Ambassador Unit Manager T and the DON shared on 1/9/2025, Manager T asked the nurse to waste #11 (pill) in the blister pack as the back of bubble pack was damaged and it was going to fall out at some point. The entry on the narcotic log from 1/9/2025 is not from the nurse administering the medication but from wasting it. Unit Manager T was queried as to why that was not indicated and where were the nurse signatures. It was shared it appeared the nurses' signatures were diagonal from the row the information was listed it. But given the disorganization of the form they were not 100% certain that was the case. Manager T agreed that should have been listed as well and that the blister back was in the medication cart for an additional six months after the medication was discontinued. On 1/14/2025 at approximately 3:30 PM, a review was conducted of Resident #61's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included, Respiratory Failure, End Stage Renal Disease, Atrial Fibrillation, Hypotension and Polyneuropathy. Further review yielded the following: Physician Orders: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone HCl Oral Tablet 5 MG- Give one tablet by PEG (percutaneous endoscopic gastrostomy) Tube every 6 hours as needed for pain. Started on 8/8/2024 and discontinued on 6/9/2024. Oxycodone HCl Oral Tablet 5 MG- Give one tablet by mouth every 6 hours as needed for pain. Started on 6/9/2024 and discontinued on 7/8/2024. Review was completed of the facility policy entitled, Controlled Substance, revised 8/2020. The policy stated, .Accurate inventory of controlled medications is maintained at all times . When a dose of a controlled medication is removed from the contained for administration but is refused by the resident or not given for any reason .the dose must be destroyed according to facility policy and the disposal documented on the accountability record on the line representing that dose . Review was completed of the facility policy entitled, Controlled Substance Disposal, revised 8/2020. The policy stated, .When a dose of controlled substance is removed from the container for administration but refused by the resident or not given for any reason . it is destroyed in the presence of two licensed nurses personnel . and the disposal is documented on the accountability record on the line representing the dose . All controlled substances remaining in the facility after a resident has been discharged or an order discontinued are disposed of .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This citation pertains to Intake Number MI00148741 Based on observation, interview and record review the facility failed to maintain sanitary conditions in the kitchen, resulting in improper kitchen sanitization of all kitchenware utilized to prepare and plate resident meals, soiled floors and ice machine potentially affecting all residents who consume meals from the kitchen Findings include: On 1/8/2025 at 10:05 AM, a tour of the kitchen was completed in the presence of Registered Dietitians E & F. The following was observed: other bilateral handles to the reach in refrigerator had debris amassed inside the handles. other bottom of the individual toaster was [NAME] with dried on food reside and other large brunt like particles. oGreen speaker was sitting atop of the clean/ready to use dishware. Registered Dietitian E & F both stated that should not be there. [NAME] the storage rack were 11 sheet pans that were still wet, as water droplets were still visible. When asked about this area it was explained dishware is placed in that area once it if fully dried and those should not be there if they are wet. Entrance floor mat to the back parking look was full of debris from grass, white-like substances and mud immersed in the circular holes of the mat. Upon moving the mat there was more debris particles that were found. oThe floor mat across from the walk-in freezer was observed to have multiple spots with dried on unknown substances on them. oThe floors throughout the kitchen were soiled with dried footprint steps and multiple areas of a white dried on substance. -The bottom lip of the ice machine was wiped with a piece of paper towel and yielded a black residue. Walk in Cooler -The blue fan cover was covered with dust debris -A baking sheet pan of cake with use by date of 1/7/25 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Walk in Freezer -Bucket of pumpkin pie filling with use by date of 1/6/25 Registered Dietitian's E & F explained they have a porter that completes different deep cleaning tasks throughout the week, which encompass the floor mats, toaster, ice machine, floors etc. The cleaning logs were reviewed back to end of December 2024 and there were many blanks that indicated daily kitchen cleaning was not being completed as required by dietary staff. Dishwasher: Dietary staff were observed completing dishes from breakfast as they prepared for lunch service. When asked the appropriate temperatures for wash and rinse cycle it was stated 160 for wash and 180 for rinse. The temperature gage on the dishwasher was observed as a load was completed and the handle on the gage did not move from about 135 . They ran it again as a dietary staff observed as well and the hand moved slightly, but still was around 140 during the cycle. During the third cycle, Registered Dietitian F watched and again the gage barely moved which indicated the wash temperature was not appropriately sanitizing facility dishware. A morning dietary staff reported it was appropriately temping this morning, and they are unsure what the issue may be or how long the wash cycle was not appropriately temping. On 1/8/2025 at 11:56 AM, the Administrator explained after speaking with the Dietary Manager and Regional, they informed her if dietary staff utilize the sprayer to the right of the dishwasher and wash dishes at the same time the wash temperature will not reach the appropriate temperature, as they are both pulling hot water at the same time. On 1/8/2025 at 12:10 PM, a review was completed of Dietary Cleaning Schedule from 12/29/2024-1/7/2024: Porter Cleaning (completes specific deep cleaning tasks in the kitchen based on the day): Week 12/29/24-1/4/25 the following cleaning tasks were not completed: -Scrub Floors -Buff floor in back room -Clean walk in and reach in -Grill -Clean big and small trash cans -Clean pot and pan area -Clean beneath tables -Clean steamtable (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Bowl racks -Clean outside ice machine -Clean outside coffee pot area/dust equipment -Wipe down tray line -Dessert racks -Rack holders PM Diet Aide: Week 12/29/24 to 1/4/25 and 1/5/25 to 1/7/25: The entire week cleaning schedule was blank indicating no cleaning was completing during their shift that week. The following items were listed: -Wipe down coffee area -Clean juice machine -Put away noon pots and pans -Clean and sanitize ice chests -Wipe down 2 food carts -Sweep and mop your area -Wipe down tray line -Clean and refill condiment holder PM [NAME] Aide: Week 12/29/24 to 1/4/25: From 1/2/25 to 1/7/25 there were no cleaning task completed by the PM cook. The following were listed to be completed: -Wipe down and sanitize prep area -Clean dish area after scraping dishes -Wipe down 2 food carts (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Clear all dishes from hall On 1/10/2025 at 11:00 AM, Senior Maintenance Director L reported its possible there is a supply and demand issue with the boilers that source the kitchen. Their contracted boiler company has ordered a new part for the boiler. Review was completed boiler company work order dated 1/10/2025, .While on site for recent visit we found the units stage controller not operating correctly not allowing boiler #2 to fire . On 1/10/2025 at 11:45 AM, Dietary Manager Q was apprised of the concerns found during the kitchen tour. Manager Q shared the porter completes deep cleaning tasks daily, but when he is not at work there is no coverage. The gage on the dishwasher was replaced yesterday and the machine has been running at the appropriate temperature. Review was completed of the facility policy entitled, Dishwashing Temperature, reviewed 1/1/2022. The policy stated, It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures .For high temperature dishwashers (heater sanitization): the wash temperature shall be 150 - 165 F . Review was completed of the facility policy entitled, Kitchen Sanitation, reviewed 1/1/2022. The policy stated, The food service area shall be maintained in a clean and sanitary manner. Kitchens, kitchen areas and dining areas shall be kept clean, free from litter .Food preparation equipment and utensils that are manually washed will be allowed to air dry .Ice machines and ice storage containers will be drained, cleaned and sanitized per manufactures instructions and facility policy .The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to act on positive influenza laboratory results timely and operationalize policies and procedures for an influenza outbreak with two Residents (#30 and 45), of two residents reviewed for positive influenza, resulting in the potential for the spread of infection to residents, staff, surveyor and visitors. Findings include: During Resident Council on 1/9/2025 at 1:45 PM, Resident Council was held in the 400 Hall sitting room. There were nine residents in attendance two being Resident #30 & #45; of the nine residents the surveyor hosting the meeting and Resident #45 were the only two with masks on due to the outbreak status of the facility. At the conclusion of resident council, Resident #30 was observed in his room directly across the hall from the sitting room, as we spoke pleasantries at the doorway the droplet precaution sign was noticed hanging on his door that was completely ajar. It was further discovered from the doorframe name plates that his roommate is Resident #45. Upon review of their records, it indicated they both were positive with influenza. It can be noted facility staff invite residents to the council meeting and would have been privy to their status. Residents #45 and #30 remained in Resident Council from approximately 1:45 PM - 3:00 PM when it concluded and exposed seven vulnerable residents. On 1/9/2025 at 3:30 PM, an interview was conducted with the DON (Director of Nursing) and Infection Preventionist N regarding Resident #30 and #45 being invited to Resident Council when they were both positive for influenza and on droplet precautions. They expressed they have encouraged both residents to remain in their room and requested they wear a mask but many times they decline, and they are not able to force them to remain in their rooms. The DON and Preventionist N were asked if it was appropriate for Resident #30 and #45 to have been invited to resident council knowing they were both positive, both agreed the residents should not have been invited and other arrangements could have been made to ensure their concerns were heard by the survey team. The DON indicated the Residents refused to stay in their room when in isolation with transmission-based precautions (TBP) for positive laboratory influenza testing and that education and encouragement to abide by the TBP was given to the Residents. The DON indicated the Residents continue to come out without the mask on and stated, We continue to educate both of them . they are not confused, they are very social gentlemen, and indicated they eat in the dining room and attend activities. When asked if there were other interventions or preventive measures tried, the DON indicated they had not done other interventions besides education and encouragement and denied offering activities in their room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/10/25 at 12:14 PM, an interview was conducted with the Infection Control Preventionist/Assistant Director of Nursing (ICP) Nurse N and the DON. A review of the onset of Resident #30's signs and symptoms revealed the Resident had a cough that started on 12/29/24 and temperatures on 12/29 at 8:54 pm of 101.4, 12/30 at 9:26 am of 102.1 and on 12/30 at 8:57 pm of 101.7 degrees Fahrenheit, as identified by the ICP who was reviewing Resident #30's medical records. The ICP indicated that the facility had tested for Covid-19 and Influenza rapid test that were negative. The ICP indicated that a respiratory panel was sent out for both Resident #30 and the roommate Resident #45 on 1/1/25 and resulted on 1/4/25 for being positive for influenza. The ICP reported not being aware of the positive influenza laboratory results until coming into the facility on [DATE]. The ICP indicated the fax was sent to the facility on [DATE] with the positive results and had not been seen by facility staff. The ICP was asked about Resident #30 and #45 starting transmission-based precautions with the onset of signs and symptoms. The DON indicated that the Residents had not been positive with the facility rapid testing, there were no other cases of influenza at the time and the Residents were not put on isolation prior to receiving the results on 1/6/25. The DON indicated that the test results had been received by fax on 1/4/25 but the DON and the ICP had not received the results until 1/6/25 and the protocol had been started with initiation of the transmission-based precautions for Resident #30 and #45, testing for influenza after the two positive results that indicated an outbreak with the health department contacted at that time and Tamiflu ordered for the Residents as well. The DON and ICP were asked why the fax machine had not been monitored when laboratory results were pending, but they were not sure and indicated they should have been aware of the results that came in on 1/4/25. The resulted lack of receiving the results timely when the facility was notified of the positive laboratory results of an influenza outbreak prevented the timely initiation of precautions, facility wide testing, and acquisition of prophylactic medication for residents. A review of Resident #30's medical record revealed the following: -Respira-ID Molecular Pathogen Report-collection on 1/1/25, report date 1/4/25, Pathogens Detected included Influenza virus. The fax information at the top of the documents indicated the 4th at 10:07 AM. The bottom of the report indicated report date on 1/4/25 and printed 1/4/20 at 10:06 am. -Order date 1/7/25, created 1/7/25, Resident is in isolation for influenza A. A review of Resident #45's medical record revealed the following: -Respira-ID Molecular Pathogen Report-collection on 1/1/25, report date 1/4/25, Pathogens Detected included Influenza A/B virus. The bottom of the report indicated report date on 1/4/25 and printed 1/4/20 at 01:51 (1:51 AM). -Order date 1/7/25, created 1/7/25, Resident is in isolation for influenza A. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility document titled Guidelines for Influenza and Respiratory Virus Outbreaks in Long-Term Care Facilities, from the Michigan Department of Health and Human Services, revealed the following, This guidance outlines Michigan Department of Health and Human Services (MDHHS) recommendations to control influenza and other respiratory virus outbreaks. Residents of long-term care facilities can experience severe and fatal illness during respiratory virus outbreaks, therefore, prompt recognition and management of outbreaks is critical. Any suspected outbreaks should prompt immediate action as outlined below . Action Steps: A single case of suspected influenza is sufficient for triggering influenza testing and prompt implementation of infection prevention and control measures, including active surveillance for new illness cases. The following should be undertaken immediately by the LTC facility with LHD coordination: .Active surveillance for additional cases should be implemented as soon as possible once one case of laboratory-confirmed influenza is identified in a facility . Antiviral Treatment and Chemoprophylaxis: If influenza is suspected or confirmed, consult with the facility Medical Director regarding antiviral treatment and prophylaxis. All LTC residents who have confirmed or suspected influenza should receive antiviral treatment immediately; treatment should not wait for laboratory confirmation. As soon as an influenza outbreak is confirmed, all non-ill residents on impacted units and wards should receive antiviral prophylaxis, regardless of vaccination status . A review of facility policy titled, Transmission-Based (Isolation) Precautions, reviewed/revised 5/22/23, revealed, . Facility staff will apply Transmission-Based Pre .1. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission . 4. Residents on transmission-based precautions should remain in their rooms except for medically necessary care . 8. Initiation of Transmission-Based Precautions, a. Nursing staff may place residents with suspected or confirmed infectious diarrhea, Covid-19, influenza, or symptoms consistent with a communicable disease on transmission-based precautions/isolation empirically while awaiting confirmation .

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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** 37771 Based on interview and record review, the facility failed to ensure immunizations were reviewed and offered for/to Resident #45, of six residents reviewed for immunizations, resulting in the potential for lack of protection against infectious diseases and illnesses and spread of infection. Findings include: On 1/14/25 at 8:55 AM, a review of Resident immunizations was conducted for the infection control task of the survey. Six residents were included in the review of immunizations. Resident #45 had been laboratory tested for Influenza with respiratory panel swab collected on 1/1/25 that resulted in positive results for influenza. A review of Resident #45's medical record revealed an admission into the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, diabetes, dependence on supplemental oxygen and influenza. A review of Resident #45's medical record of Immunizations, revealed TB 2 Step Mantoux Skin Test date administered 10/3/24, Sars-Cov-2 (Covid-19) [NAME] date administered 12/13/21 and PCV13 date administered 3/12/2019. There was no data for Influenza and no further data for Covid-19 or pneumonia immunizations received or refused. On 1/14/25 at 1:24 PM, an interview was conducted with the Infection Control Preventionist (ICP), Nurse N regarding the lack of information for Resident #45's immunizations. The ICP reviewed the resident's medical record and reported it was lacking information of immunizations. The ICP indicated he had seen any refusals for vaccinations in the Resident's medical record. The ICP stated, I don't know how he got missed. I think there is something with his name. He does not pull to the reports. The audit report pulled on 1/7/24 was reviewed with the ICP. The ICP indicated he had selected all residents, and Resident #45 was not on the list. The ICP was unable to find documentation that the Resident had been offered or received vaccinations or had refused any vaccinations while residing at the facility. A review of facility policy titled, Infection Prevention and Control Program, reviewed/revised 12/27/23 revealed, . 7. Influenza, Pneumococcal and Respiratory Syncytial Virus (RSV) Immunization: a. Residents are offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time . f. Documentation should reflect the education provided and details regarding whether or not the resident received the immunizations . A review of facility policy titled, Influenza Vaccination, date reviewed/revised 10/26/23, revealed, .2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine . 8. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to maintain a clean/sanitary, safe, and homelike environment with soiled privacy curtains in rooms 207, 505, 507, 509; Call lights not within reach for Resident #3, #35, #105 and room [ROOM NUMBER]-1; Respiratory equipment not stored properly for Resident #102, #57 and #407 soiled wheelchairs, geri chairs and walker stored in the common/dining area on the 300 hall; ceiling tile coming down in the bathroom between rooms [ROOM NUMBERS]; multiple bathrooms on the 300 hall with personal wash basins stored improperly and not labeled with resident information; denture cups in room [ROOM NUMBER] not properly labeled with resident information; and a lack of paper towel available in room [ROOM NUMBER], of 6 halls/units reviewed for environmental concerns, resulting in a lack of resident and staff safety, and the potential of needs not met, spread of infectious disease, and dissatisfaction of living conditions. Findings include: Common area/dining room on the 300-Hall On 1/8/25 at 1:32 PM, an observation was made in the common area/dining room. Residents were eating lunch at this time. An observation was made of wheelchairs and Geri chairs/reclining chairs stored in the common area/dining room. One wheelchair had dried substance on the seat, and had debris on the handles, brakes, frame and wheels. Another wheelchair had whitish debris on the seat cushion and frame and wheels were dirty. A Geri chair had whitish debris on the seat cushion and leg area. The other Geri chair/recliner chair has ripped fabric hanging from the leg rest and the chair is not clean. There is a walker stored in the dining area and not near any of the Residents eating lunch. The walker has a basket under the seat cushion that is filthy, the seat cushion had multiple rips that exposed the padding. The handle/brakes and wheels are filthy with debris. Resident #35 and Resident in room [ROOM NUMBER]-1 A review of Resident #35's medical record revealed an admission into the facility on [DATE] with diagnoses that included encephalopathy, multiple sclerosis, seizures, history of benign neoplasm of the brain, lack of expected normal physiological development in childhood, muscle wasting and atrophy, and hemiplegia affecting left nondominant side. A review of Resident #35's MDS revealed a BIMS score of 3/15 that indicated severely impaired cognition, and the Resident needed substantial/maximal assistance with eating and was dependent on staff for other activities of daily living and most transfers. On 1/8/25 at 1:10 PM, an observation was made of the Resident in room [ROOM NUMBER]-1 lying in bed sleeping. An observation was made of the call light not within reach for the Resident. Resident #35 was not in the room at this time. An observation was made of Resident #35's call light laying on the floor near the head of the bed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/24 at 2:23 PM, an observation was made of Resident #35 in bed with the head of the bed elevated. The resident was interviewed, answered some questions and was limited with responses. The Resident had bilateral floor mats to either side of the bed. The Resident had a cup with orange juice and was trying multiple times to pick the cup up. The Resident was leaning at a slightly odd angle. The Resident asked the surveyor to help her sit up better so she could drink her orange juice. The Resident was asked where her call light was, and she stated she did not know where to find it. An observation was made of the call light laying on the floor near the head of the bed. The Resident was asked if they keep the call light in reach for her and the Resident stated, It falls a lot. An observation was made of no visible clip on the cord and the Resident stated, That would help. The Resident asked for assistance again and staff was summoned to the room and notified of the call light on the floor. Storage of wash basins. Ceiling tile. On 1/8/25 at 12:51 PM, an observation was conducted of room [ROOM NUMBER]'s bathroom with multiple pink basins in the bathtub. The bathtub faucet is dripping water. Resident in 301-1 reported staff use the pink basins, fill them up for us and then we can get washed up and indicated they use them every day. Resident in 301-2 reported she also uses the basins. Another observation was made and there were three basins inside the bathtub and one basin on the side of the tub, none of the basins had Resident identifying information on them. A denture container was in the bathroom by the sink area and did not have Resident identifying information on it. Both Residents indicated they have dentures. On 1/8/25 at 1:10 PM, an observation was conducted in room [ROOM NUMBER] with two residents that occupied the room. An observation was made of four wash basins that were stacked two by two and had no Resident identifying information on them. The basins had bottles of soap that had no resident identification on the bottles. On 1/8/25 at 1:21 PM, an observation was conducted in room [ROOM NUMBER] with one resident that occupied the room and shared a bathroom with room [ROOM NUMBER] that had two residents. An observation was made of two basins stacked together, and a graduated cylinder stored on the back of the toilet. The items had no resident identifying information. On 1/8/25 at 2:09 PM, an observation was made in the bathroom between rooms [ROOM NUMBERS]. Two residents resided in each room. An observation was made in the shared bathroom between the rooms of a ceiling tile bowing down and a cold breeze noted in the bathroom. On 1/9/24 at 9:35 AM, an observation was made in room [ROOM NUMBER], that had two residents residing in the room, of no paper towel available in the bathroom and no other towels available in the bathroom or the room for hand washing. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/24 at 10:30 AM, the Maintenance Staff and Maintenance Director L were asked to make an observation with the surveyor of the bathroom between 300 and 302. The ceiling tile was bowed out and hanging and there was a cool breeze in the bathroom. The Maintenance Director indicated he had not been made aware of the tile and would have it fixed immediately. The ceiling tile was not able to be put back into place and the Maintenance Director reported they would get a new tile to go in and reported it will help alleviate the draft in the bathroom. When asked about lack of communication about the ceiling tile, the Maintenance Director reported that staff can call them directly or use the TELS communication on the computer and stated, As long as they (staff) tell us about it, we try to get to it right away. On 1/10/25 at 4:25 PM, an interview was conducted with the Infection Control Preventionist/Assistant Director of Nursing (ICP) N regarding facility policy on storage of wash basins in the resident bathrooms. The ICP indicated that basins should be labeled with resident identification and stored in the bedside or in the bathroom. Observation of bathrooms in the 300 hall was conducted with the ICP. Upon observation of basins in the bathroom in room [ROOM NUMBER] and the bathroom between 304 and 306 of multiple basins, some stacked together without Resident identifying information. The ICP reported the basins should not be stored this was and should have resident identification on them. In the bathroom of room [ROOM NUMBER], the pink basins continued to be stored in the bathtub and the faucet on the tub was dripping water. The ICP indicated he was not aware of the leaking faucet and reported the basins should not be stored in the bathtub. When asked about the denture cup without resident identification, the ICP indicated they will get a new denture cup and that it will be marked with the resident identification. The ICP made an observation, with the surveyor, of the 300-hall dining/common area of the storage of wheelchairs, Geri chairs and walker. The ICP indicated that to keep the hallways decluttered they will store some of the Residents wheelchairs and walkers in the bathrooms or in the dining area. An observation was made of the whitish substance on the cushion of the Geri chair and wheelchair and the debris on the seat, wheels, frame and brakes of the wheelchairs and Geri chairs observed in the dining/common area. One Resident tag the ICP identified that the Resident had left the facility about one and half weeks ago. The ICP reported that there were other areas for storage for the items, and stated, they should be cleaned. The walker was identified as one that belonged to a Resident in the 300-hall. The walker was filthy and had rips in the seat cushion that exposed the foam underneath. The bag for personal belongings was filthy. The ICP indicated that it needed to be addressed, changed and cleaned. 22348 FACILITY Environment Call Light: Resident 105 (R105) (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation tour on 1/8/24 at 1:32 PM R105 was observed eating alone in her room. She was using one hand while she was slowly feeding herself. R105 was not wear a clothing protector while eating. There were food debris scattered all over her chest and her bed. The television was set too loud while the surveyor repeated the questions to R105 was trying to find the TV remote to adjust the volume. The TV remote and the call light were found on the floor right next to each other. The R105 felt relieved after the volume of the TV was lowered and found the call light with her remote. She said thank you and stated that she was looking for them. The surveyor attempted to placed the call light within reach but observed that there was no clip to anchor the call light cord in place. The surveyor attempted to find a staff in the hall to help assist R105 but there was no one in the hall at the time of observation to alert staff regarding the call light and the clothing protector incident. A record review was conducted on 1/9/25 at 1: 35 PM. According to R105's Electronic Medical Record (EMR), R105 was [AGE] years old admitted to the facility on [DATE], with a diagnosis of Hemiplegia and Hemiparesis following cerebrovascular disease, Aphasia, and Cerebral Infarction due to Occlusion or Stenosis of the Left Vertebral Artery in addition to other diagnoses. R105's BIMS score assessed on 10/23/24, was 3/15 which means that R105 has severe cognitively impairment as a result to the recent stroke on April of 2024. Minimum Data Set, dated dated dated with an assessment date of 10/23/24, Section GG revealed: R105 in the Daily Activity Task, Eating: it required supervision or touching assistance. This was further was explained: The helper provides verbal cues or touching steadying assistance as resident completes the activity. R105's care plan initiated on 4/16/2024 and revised on 10/24/24, revealed that R105 has an ADL self-care performance deficit related to subacute infarction in the left MCA territory resulting in aphasia, right upper/lower side hemiplegia. R105 used left hand for her dominant hand prior stroke. R105 has poor balance, poor coordination with decrease strength and endurance. Respiratory Equipment: During initial tour on 1/8/24 at 11:10-11:40 AM the following room numbers had respiratory equipment (oxygen. nebulizers and CPAP) at bedside. It was observed: room [ROOM NUMBER] R102 was in room [ROOM NUMBER] was observed on 1/8/25 at 11:10 am. R102 had a nebulizer (mask and tubing) on the bedside table and was not put away by staff neatly nor sanitarily. The nebulizer was sitting on the bedside table next to his urinal that was half filled with urine. Other items on the side table along with the nebulizer and urinal were his snacks and beverages served by the facility. The nebulizer tubing was found undated nor an indication that it was changed or a replaced on a regular basis. The nebulizer mask did not have a date nor secured in a bag for infection control prevention. A Record Review on 1/9/25 at 1:30 PM, revealed R 102's Brief Interview Mental Status BIMS Score of 15/15. This means that the resident's mental/cognitive status is intact. room [ROOM NUMBER] (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R57 was observed in her room on 1/8/25 at 11:30 AM. R57 had a CPAP machine on her bedside table exposed for anyone that comes in and out. R57 stated she used them last night staff forgot to put them away. A Record Review on 1/9/25 at 1:30 PM showed a Brief Interview Mental Status BIMS Score of 15/15. This means that the resident's mental/cognitive status is intact. room [ROOM NUMBER] R64 was observed in her room on 1/8/25 at 11:40 AM and a Continuous Positive Airway Pressure (CPAP) machine at the bedside table was observed not secured in a bag, not labeled and no date was found. R64 revealed she used it last night. A Record Review on 1/9/25 at 1:30 PM showed a Brief Interview Mental Status BIMS Score of 07/15. This means that the resident's mental/cognitive status is moderately impaired. 38471 Privacy Curtains: During initial tour on 1/8/2025 and 1/9/2025, privacy curtains in resident rooms were noted to be soiled with varying colors of unknown substances. The following rooms were noted: 207-1-Stains on both sides of the curtains 207-2-Stains on both sides of the curtain 505-1- Privacy curtain has stain in multiple areas-on both sides 505-2- Varying stains in multiple areas 507-1- Black stains on both sides of the curtains in varying spots 507-2- Multiple stains in varying spots and on both sides. The resident was unable to recall when the last time they were laundered. 509-2- Two curtains in the rooms have stains/spots in varying places on the curtains On 1/10/2025 at 2:40 PM, Laundry/Housekeeping Manager D and Area Supervisor C were asked if they were responsible for privacy curtains as well and they reported they are. Manager D' was asked the last time an audit was completed on the privacy curtains, and it was stated about two weeks ago, and they found about a handful that needed to be changed. They added there are additional sets in the facility and staff will wash then hang dry them. A tour was completed of the soiled utility curtains on the 500 and 200 units. Manager D reported some of the curtain could be laundered and others would have to be discarded. Review was completed of the Housekeeping Daily Job Routine, and it does not list checking the privacy curtains while they are cleaning each room.