STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235234	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Nursing and Rehab Center	9500 Grand River Ave Detroit, MI 48204

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 22349 Based on observation, interview, and record review, the facility failed to follow the standards of practice for medication administration when 1.) an insulin pen was not primed (remove air bubbles from needle and cartridge) prior to administration of insulin to R53, 2.) medications through a PEG (feeding tube that is surgically placed through the abdominal wall directly into the stomach) were not individually crushed and separately flushed through the PEG tube for R9 and 3.) a physician's order for an anti-hypertensive medication was incorrectly transcribed on the Medication Administration Record (MAR) for R9, resulting in the potential for an inaccurate amount of medication to be administered and decreased efficacy of the medications. Findings include: RR53 On 12/19/24 at 8:33 AM, Licensed Practical Nurse (LPN) E was observed preparing to administer 35 units of lantus insulin to R53 at the medication cart. LPN E retrieved a new lantus insulin pen and dialed the insulin pen to 35 units. LPN E proceeded to R53's bedside to administer the insulin. LPN E was queried on the process of insulin administration from a pen. LPN E did not know what 'priming' was and did not prime the insulin pen prior to administration of the insulin to R53. According to the undated manufacturer's guidelines for use of insulin pen: It's important to prime the pen before every injection when using any insulin pen. If you don't prime before each injection, your dose may be lower than intended due to air collection in the insulin reservoir. To prime the insulin pen dial the dose knob to select '2', hold the pen so the needle is pointing upward, tap the cartridge to collect any air to the top, and depress the injection button. A few drops of insulin should be seen, if not repeat the process until drops of insulin are seen. According to the facility's policy for Insulin Pen implemented on 11/1/2022 in part read: 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. R9 (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 9:00 AM LPN E was observed at the medication cart preparing medications for R9. R9 had orders to have the following seven medications administered through a PEG tube. LPN E placed all the medications in one medicine cup: 1) ferrous sulfate 325 mg (milligrams) 1 tablet 2) folic acid 1 mg 1 caplet 3) paroxetine 10 mg 1 tablet 4) asa 81 mg 1 tablet 5) vitamin d3 1000 mcg (micrograms) 6) vitamin C 500 mg 7) zinc 50 mg LPN E then placed all seven medications in one plastic sleeve to crush all the medications together. LPN E was asked if all the medications should be administered together through the PEG tube. LPN E replied Yes. LPN E was asked to review the policy prior to administering all seven medications together through the PEG tube. According to the facility's policy for Medication Administration via Enteral Tube (PEG tube) implemented on 11/1/2022 in part reads; It is the policy of this facility to ensure the safe and effective administration of medications via feeding tubes by utilizing best practice guideline 6. Each medication will be administered separately, not combined 11. Procedure: - i. Flush the enteral tube with at least 15 milliliters (ml) of water prior to administering medications. - j. Dilute the medication and administer. - k. Flush the tube with at least 15 ml of water to ensure drug delivery. - l. Repeat with the next medication. R9 On 12/19/24 at approximately 9:00 AM, during observation of R9's medication administration, LPN E said, The resident has Metoprolol Tartrate 0.5 mg dose prescribed on the orders and that's what is on the MAR (medication administration record), but Metoprolol Tartrate 12.5 mg dose is what is available in the medication cart. LPN E did not give the Metoprolol Tartrate 12.5 mg to the resident at this time and called the physician for clarification. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 11:44 AM PM, the Director of Nursing (DON) said, After speaking with the physician and the pharmacy it was determined that the physician had ordered the resident (R9) to receive Metoprolol Tartrate 25 mg, half a tab to equal twelve and one half (12.5) milligrams. Not one half (0.5) of a milligram. It was a transcription error. The resident had been receiving the correct dosage of 12.5 mg. The DON acknowledged that the transcription error occurred on 11/24/24 and had not been clarified until 12/19/24 (25 administrations later). The DON acknowledged that the transription error should have been clarified and corrected earlier. According to the facility's policy for Medication Reconciliation implemented 11/1/2022 in part reads; Medication reconciliation refers to the process of verifying that the resident ' s current medication list matches the physician ' s orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay. 1. Medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff. 5. Daily Processes: a. Address any clinically significant medication irregularities reported by pharmacy consultant. b. Verify medication labels match physician orders and consider rights of medication administration each time a medication is given. c. Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed.

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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** 15194 Based on observation, interview and record review the facility failed to provide hair care for two residents (R5 and R7) and a shave for one resident (R16) out of a sample of 14 residents reviewed for activities daily living (ADL's), resulting in unmet hygiene needs, loss of dignity and emotional distress. Findings include: On 12/17/24 at 10:20 A.M. during a tour of the third floor, R5 was identified as receiving care from a hospice company. The resident's hair was observed loose, standing straight to the ceiling and matted on the left side of R5's head. Mingled in the resident's hair were white balls and lint from the linen on the bed. R5 was observed on 12/18/27 at 1:50 P.M. and again on 12/19/24 at 12:00 P.M. R5's hair had not been combed and the presence of white lint balls were more pronounced. On 12/18/24 at 6:00 P.M. during an interview with the resident's guardian and brother, both family members mentioned that R5's hair at one time was combed by staff but had been told after inquiring that the Aide no longer worked at the facility. The guardian indicated R5's hair had not been combed or washed in a while and since the resident couldn't do it for herself it would be nice to observe R5 with her hair combed or braided. The guardian indicated R5's family was very involved in the resident's care and indicated, 'I don't think any person would like their hair all over their head. I don't think they even try to do anything to her hair. Review of the Admission Face Sheet for R5 indicated the resident was admitted to the facility on [DATE], with diagnoses of acute respiratory disease, sarcoidosis, paranoid schizophrenia, anxiety disorder, Alzheimer disease, hypertensive heart disease, and gout. According to the Minimum Data Set MDS) assessment dated [DATE], R5 was severely impaired in cognitive skills for decision making, was incontinent of bowel and bladder and required one-two person to perform activities of Daily Living. Review of R5's care plan dated 7/5/22 revised 12/6/24 documented the following: I have a self-care deficit related to weakness, impaired balance and impaired cognition due to diagnoses of Alzheimer. R7 On 12/17/24 at 10:40 A.M. during an observation, R7's hair was observed pulled into a knotted ponytail positioned in the middle of the resident's head. R7's hair was tangled and twisted under a broken rubber band. R7 was observed with both hands contracted, requiring staff to feed the resident. R7 was asked if staff combed or brushed her hair. R7 responded No. According to the Minimum Data Set (MDS) assessment dated [DATE], R7 was moderately impaired for cognitive skills for decision making (required supervision), had no psychosis, no physical or behavioral difficulties and was always incontinent of bowel and bladder. (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 the care plan dated 7/13/21, revised 10/16/24, documented, I have a self-care deficit related to diagnoses: tachycardia, history of cardiovascular accident, diabetes mellitus, hypertension, I require assist with ADL's unable to make needs known, hearing and vision adequate. I prefer for my nails not to be cut. According to the Admission Face sheet R7 was admitted to the facility 9/17/2018, with pertinent diagnoses of cerebral infraction, chronic systolic congestive heart failure, mild cognitive impairment, diabetes mellitus, and major depression. R16 On 12/17/24 at 10:50 P.M., R16 was observed with a thick mucus coating around his mouth. On 12/18/24 at 12:30 P.M. R16 (who was legally blind) was observed being taken for an appointment with a (1/2 inch long) visible speckled facial beard. R16 was observed on 12/20/24 at 10:54 A.M. with the front of his gown soiled with milk and scrambled eggs from breakfast. According to the MDS assessment dated [DATE] R16 was cognitively intact for decision making skills exhibited no physical, verbal or behavioral symptoms in the last 90 days, had upper and lower impairments on both sides and was always incontinent of bowel and bladder . Review of the revised care plan dated 10/24/24, documented, I have a self-care deficit related to impaired vision, weakness, impaired mobility I require supervision and assistance to perform my ADL care. According to the Admission Face Sheet R16 was admitted to the facility on [DATE] with diagnoses which included: Chronic obstructive pulmonary disease, legal blindness, type 2 diabetes, heart disease, schizoaffective disorder and cerebral infract. On 12/19/24 at 2:00 P.M., in an interview with Licensed Practical Nurse (LPN)' R concerning who was responsible for grooming female resident's hair and providing shaves for the men. LPN R explained she thought R5's hair was taken care of by the hospice company that came in to provide services but was not sure if the two aides assigned to the unit could provide that care consistently since they had five residents that physically had to be fed their meals. LPN R stated the Activity Department had been given that assignment but was not aware if any of the residents on the unit had been provided the services. On 12/20/24 at 9:00 A.M., during interview with the Activity Director concerning residents from the third floor who had been referred or received a request to have their hair combed or men shaved, the Activity Director indicated none of the Activity assistance had been asked or directed to provide services on the third floor. The Activity Director explained the departmment just started to provide the service to everyone. The Activity Director added there was a barber that comes in for the men but there was no beautician for the women. Review of the facility's policy titled Activities of Daily Living (ADL's) dated 11/2/22 in part stated: Care and services will be provided for bathing, dressing, grooming and oral care. The facility will maintain individual objectives of the care plan and periodically review and evaluate.

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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** 22349 Based on observation, interview, and record review, the facility failed to ensure appropriate supra-pubic catheter care for one (R37) of two residents reviewed for catheter care, resulting in discomfort at the insertion site, the potential for dislodgment of the catheter, and urinary tract infection. Findings include: On 12/17/24 at 1:02 PM R37 was observed in a wheelchair in the hallway with a catheter tubing pulling straight down from the resident's lower abdomen to a collection bag that was hanging from the back of the wheelchair frame. The catheter tubing was taut and had dark amber urine with some mucus draining into a collection bag with a dignity cover. The resident said he wanted his catheter repositioned because it bothered him. R37 went to his room and lifted his shirt to reveal the a supra-pubic (s/p) catheter insertion site (supra-pubic or s/p catheter is a flexible tube surgically inserted through the lower abdomen directly into the bladder to drain urine). The s/p cath insertion site was slightly reddened and had a small amount of dried yellow crust around the tubing. There was no dressing at the insertion site and no anchoring device to secure the catheter to the resident's abdomen. At this time Certified Nursing Assistant H was asked about R37's catheter and replied, Its up to the nurse to care for the catheter. On 12/18/24 at 2:49 PM R37 was observed in a wheelchair in the hallway with the s/p catheter tubing coiled up on his lap and the collection bag is resting in the wheelchair next to resident, at the level of bladder (not below). Upon further inspection of R37's s/p catheter while in the resident's room, there is no anchoring of the catheter tubing or dressing to the insertion site. The insertion site had yellow crust around site. Yellow urine was draining into the collection bag. R37 denied pain at the site but said, It bothers me at times and sometimes they don't put a dressing on it. The doctor said I should have tape on it. On 12/19/24 at 8:17 AM R37 observed sitting in his room in a wheelchair. The s/p catheter was tucked inside his sweat pants along with the urinary collection bag. The collection bag was not below the level of the resident's bladder. There was no anchoring device or dressing on the insertion site. R37 placed his bare hands on the s/p catheter tubing and said, I don't know why they don't do anything with this. It's been pulled out before and I had to go to the hospital to have it put back in. R37 denied pain at the insertion site, but said, It's uncomfortable sometimes. On 12/19/24 at 12:06 PM Licensed Practical Nurse (LPN) E was asked about R37's s/p catheter care. LPN E observed R37's catheter and acknowledged that the resident should have an anchoring device on his catheter to prevent dislodgement but that he (R9) refuses at times. LPN E could not recall what catheter care had been completed for R37. LPN E did not reposition R37's urinary collection bag to a level lower than the resident's bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to R37's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included neuromuscular dysfunction of the bladder, muscles spasms, and complications of the supra-pubic catheter. According to the resident's Minimum Data Set (MDS) dated [DATE] R37 had no cognition impairment and was independent with hygiene and transferring from surface to surface. A physician's order dated 3/8/24 for s/p catheter care is as follows; cleanse s/p catheter with normal saline, pat dry apply dry dressing if drainage and secure with tape. The Treatment Administration Record (TAR) included the following order for S/P catheter: ensure catheter is secured to the thigh. Change securement device as needed. Check every shift. A care plan for supra-pubic catheter care initiated on 2/10/22 included the following interventions; position collection bag below the level of the bladder. A progress note dated 9/19/24 revealed that R37's s/p catheter had become dislodged. R37 was transported to the emergency room for replacement of s/p catheter. According to the facility's Catheter Care policy implemented on 11/1/2022 read in part: 1. Catheter care will be performed every shift and as needed by nursing personnel. 9. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 22349 This citation pertains to intake MI00148648. Based on observation, interview, and record review the facility failed to establish a record of receipt, disposition, or reconciliation of controlled drugs (a drug that the government regulates for possession and use, i.e. narcotics) in the facility's back-up box (secured storage unit of controlled drugs), resulting in the facility being unable to account for the receipt of, disposition of, or discrepancies of controlled drugs in the facility's back-up box with the potential for drug diversion and controlled drugs being unavailable to administer to residents as prescribed. Findings include: On 12/19/24 at 12:52 PM observation of the facility's narcotic back-up box with the Director of Nursing (DON) revealed there was no plastic lock on the narcotic drawer. The lack of a lock indicated that the narcotic drawer had been opened after pharmacy had delivered a fully restocked narcotic supply. There was no documentation to indicate when pharmacy last delivered the back-up-box or when narcotics had been removed. A sheet of paper with multiple undated entries indicated narcotics had been removed. The last dated entry was 11/18/24 (31 days earlier) and indicated that an oxycodone 5 milligrams (mg) had been removed leaving 5 in the back-up-box. Upon visual inspection of the oxycodone 5 mg box there were 3 tablets present. The DON was asked how the facility reconciles narcotics taken from the back-up-box. The DON could not determine when narcotics had last been delivered from pharmacy, the number of narcotics that were delivered from pharmacy, what facility nursing staff received the narcotics, or when narcotics had been removed from the back-up-box. The DON could not explain the facility's process for narcotic reconciliation, what the plastic locks on the narcotic drawer were used for or if any dispensing forms were utilized. At this time the number for the pharmacy was requested. On 12/19/24 at 2:40 PM during a phone interview the facility's pharmacist (PH) M said that the pharmacy delivers a fully stocked back-up-box every week with a numbered plastic lock on it. The last delivery was on 12/10/24 and according to the dispensing sheets the following number of narcotics should be present. -Oxycodone 5 mg should have 4 tablets available for dispensing. Upon visual inspection there were 3 tablets available. (one tablet unaccounted for) -Norco 5 mg should have 3 tablets available for dispensing. Upon visual inspection there were 4 tablets available. (one tablet extra) -Norco 10 mg should have 5 tablets available for dispensing. Upon visual inspection there were 3 tablets available. (two tablets unaccounted for) -Percocet 5 mg should have 5 tablets available for dispensing. Upon visual inspection there were 5 tablets available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PH M could not account for the discrepancy in numbers of narcotics and said, We only have what dispensing forms the nursing staff fax to us. That is all we have. I don't know why the numbers don't match up. I will send someone out there tomorrow to reconcile the back-up-box. According to the facility's Pharmacy Services implemented 2/19/24 in part read: The facility in coordination with the licensed pharmacist, will provide for: a. A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications; b. Prompt identification of loss of or potential diversion of controlled medications; and c. Determination of the extent of loss or potential diversion of controlled medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview and record review the facility failed to obtain and address Medication Regimen Review (MRR) recommendations timely for two residents (R35 and R54) of five residents reviewed for medication regimen review, resulting in the continuance of unnecessary medications and a lack of communication of recommended medication changes between pharmacist and physician. Findings include: R35 On 12/20/24 at 12:00 P.M. review of monthly Pharmacy recommendations in the electronic Medical Record for R35, documented the following: Date: 9/9/24 Pharmacist Drug Regimen Review Please take the following action, described below See report. Recommend: please consider reducing this: Resident is on sliding scale insulin (Adelog) AMDA guideline does not suggest using sliding scale insulin because of its retrospective way Of treating hypoglycemic and the lack of evidence to support its efficiency in physiological needs of the body More according to the American Geriatric Society updated Beers Criteria, there is also to this recommendations a higher risk hyperglycemia without improvement in hypoglycemic management. Please consider reducing or discontinuing the use of SSI The Physician Prescriber responded and disagreed with the recommendation for the months of February, April 2024 and 9/9/24; however the physician did not review the pharmacist recommendation until 12/19/24. Record review of R35 Electric Health Record (EHR) revealed R35 was admitted into the facility on [DATE], with a recent readmission on 10/25/2024, with diagnoses of: Diabetes Mellitus type 2, chronic obstructive pulmonary disease with (acute exacerbation), dementia with behavioral disturbance, atherosclerotic heart disease, morbid obesity and chronic kidney disease. According to the Annual Minimum Data Set, dated dated dated (MDS) 11/18/24 R35 was moderately impaired in cognitive skills for decision making. R54 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of R54's Electronic Health Record (EHR) revealed R54 was admitted into the facility on [DATE] with most recent readmission on 10/1/24 with diagnoses that included cerebral infarction (stroke), major depressive disorder, adjustment disorder with mixed anxiety and depressed mood. According to the quarterly Minimum Data Set (MDS) dated [DATE], R54 had intact cognition. Review of R54's physician orders documented the resident's current medication as follows: -Xanax (alprazolam)- Schedule IV tablet; 0.5 mg (milligrams); amt (amount) ;1 oral. Special instructions take one tablet by mouth twice daily as needed. Start date 10/12/24. End date open ended. Review of monthly pharmacy recommendations in the electronic medical record documented the following: -10/12/24- Pharmacist Drug Regimen Review . Please take the following action described below . See report: Recommend discontinuing PRN use of Xanax 0.5 mg BID for this resident OR reorder for a specific number of days, per the following federal guidelines . The Physician/Prescriber did not respond to this recommendation. -11/13/24- Pharmacist Drug Regimen Review . Please take the following action described below . See report: Recommend discontinuing PRN use of Xanax 0.5 mg BID for this resident OR reorder for a specific number of days, per the following federal guidelines . The Physician/Prescriber did not respond to this recommendation. On 12/20/24 at 9:35 AM the Director of Nursing (DON) was interviewed and said she receives the pharmacist irregularities report and then distributes them to the unit managers where they mark them for physician review. The DON agreed the physician did not respond timely for the irregularity reports and said the expectation is 30 days or less.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview and record review, the facility failed to justify the use of a PRN (as needed) antianxiety medication and document the rationale for open ended use for one resident (R54) of five residents reviewed for unnecessary medications. Findings include: Record review of R54's Electronic Health Record (EHR) revealed R54 was admitted into the facility on [DATE] with most recent readmission on 10/1/24 with diagnoses that included cerebral infarction (stroke), major depressive disorder, adjustment disorder with mixed anxiety and depressed mood. According to the quarterly Minimum Data Set (MDS) dated [DATE], R54 had intact cognition. Review of R54's physician orders documented the resident's current medications as follows: -Xanax (alprazolam)- Schedule IV tablet; 0.5 mg (milligrams); amt(amount) ;1 oral. Special instructions take one tablet by mouth twice daily as needed. Start date 10/12/24. End date open ended. There was no 14 days stop date noted to the order. Review of R54's care plan revealed Problem: start date: 4/21/2022 Category Psychotropic Drug Use Resident is at risk for adverse consequences related to receiving antidepressant/antianxiety medication for treatment of Depression and anxiety. Goal: Short Term Goal Target Date: 10/27/24. There was no gradual dose reduction or medical justification to continue the Xanax past 14 days found in the EHR. On 12/20/24 at 9:14 AM Social Worker (SW) O was interviewed and said there is no gradual dose reduction attempt for the Xanax or rationale for continued PRN use past 14 days in the EHR. SW O further said typically the visiting psychiatry group monitors the anti-psychotropic medications, but this was overlooked. On 12/20/24 at 9:35 AM the Director of Nursing (DON) agreed the physician did not respond to the pharmacist irregularity report from 10/12/24 and 11/13/2024 or document in the EHR justification for continued use of the as needed psychotropic past 14 days. The DON said the expectation is that the visiting psychiatry group monitors psychotropic medications and that the current psychiatry group did not address R54's Xanax.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on observation, interview, and record review the facility failed to ensure that one resident (R9) was free from significant medication errors out of six residents reviewed for medication administration when only two doses of an antibiotic eye solution (Erythromycin Ophthalmic solution) was administered to the resident of the 56 doses prescribed, resulting in potential for prolonged signs and symptoms of a right eye infection. Findings include: On 12/17/24 at 12:07 PM R9 was observed lying in bed with tube feeding infusing through a feeding tube. The resident's right eye was sunken in and the lids were closed (the eyeball was not visible). A small amount of dried yellow crust was present on both the upper and lower lid. R9 was unable to be interviewed due to severe cognitive impairment. At 1:20 PM, R9's family member was interviewed and reported the resident had a right eye infection last month that was treated with antibiotic eye drops. R9's family member said the right eye infection had improved because there was less drainage than before. According to R9's Electronic Health Record (EHR) the resident initially admitted to the facility on [DATE] with multiple diagnoses that included history of a stroke, dysphagia (difficulty swallowing), a feeding tube for nutrition/hydration, and a ruptured right eye with partial loss of intraocular tissue. The Minimum Data Set (MDS) for significant change dated 12/10/24 indicated the resident had severely impaired cognition status and was totally dependent on staff for all Activities of Daily Living (ADLs). A nurse's progress note dated 11/5/24 at 2:43 PM read: Therapy staff noted the resident had some drainage from the right eye. Resident was observed with dried, green-tinged drainage from the right eye. The Physician's log was updated and the Infection Control Nurse was notified. On 11/6/24 at 7:18 PM a nurse's progress note indicated the physician ordered erythromycin ophthalmic solution for the right eye only, every 4 hours. (there was no time frame, or end date). On 11/6/24 at 9:49 PM a Physician's progress note read in part: patient was seen at the request of nursing staff due to right eye drainage Did have obvious right-sided purulent drainage, eyelids stuck to each other. Assessment/Plan: right eye bacterial conjunctivitis. The Physician's orders were as follows: Erythromycin ophthalmic solution. Clean right eye the place drop in right eye four times a day. (there was no time frame or end date). Review of R9's November 2024 Medication Administration Record (MAR) revealed two separate orders; 1.) Erythromycin ophthalmic solution to right eye and 2.) Monitor for adverse side effects for antibiotic therapy of Erythromycin ophthalmic solution for 14 days 11/7/24 - 11/21/24. R9 only received the Erythromycin ophthalmic solution to the right eye for one day; 11/7/24 at 9:00 AM and 1:00 PM, (two times). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 8:38 PM Nurse Practitioner (NP) G 's progress notes read in part: right eye has purulent drainage with eyelids stuck to each other. Assessment/Plan; right eye bacterial conjunctivitis. On 12/20/24 at 11:02 AM, NP G was asked about R9's right eye drainage. NP G said R9's right eye had improved after a 14-day course of antibiotic eye drops. NP G was asked to review and clarify the resident's antibiotic eye drop orders. NP G said, The order for the eye drops is 4 times a day and monitor for 14 days. She (R9) was supposed to receive a 14-day course of the antibiotic eye drops and be monitored while getting the eye drops. Not two seperate orders. Why would the eye drops only be for one day and the monitoring be for 14 days? That makes no sense. NP G said the orders were transcribed incorrectly on the MAR and the resident will be re-evaluated to determine if another order for the antibiotic eye drops needs to be prescribed. On 12/20/24 at approximately 11:10 AM during an interview with the Director of Nursing (DON) she reviewed R9's MAR and said, The order was transcribed wrong. The resident should have got the eye drops for 14 days, not just monitored for 14 days.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15194 Based on observation, interview and record review, the facility failed to ensure proper communication/documentation of Hospice services provided to one Resident (R5) of two reviewed for Hospice services, resulting in a lack of coordination of comprehensive services and care provided to the resident. Findings include: A review of R5's Electronic Medical Record (EMR) revealed an admitted [DATE], with diagnoses of acute respiratory disease, sarcoidosis, paranoid schizophrenia, anxiety disorder, gout and hypothyroidism. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R5 was rarely understood and was severely impaired in cognitive skills for decision making, was incontinent of bowel and bladder and required one- two person to perform Activities of Daily Living (ADLs). On 12/18/24 at approximately 11:00 A.M. License Practical Nurse (LPN) R was queired concerning the location of the documentation from the hospice company that coordinated care with the facility. LPN R indicated the hospice logbook should be on the unit but was uncertain of the location. At approximately 12:10 P.M. a hospice notebook was presented and reviewed. During the review of the hospice notebook, it was noted there were no nursing notes or visits recorded, only a schedule of dates of visitations from the Social Worker, Chaplin and Nurse Aide. There were no notes or evidence of visitation for the nurse. Per care plan dated 5/24/24, revised 10/18/24, R5 was admitted to hospice services, interventions included in part: Facility and hospice services to provide collaborative care including comfort care, palliative and end of life care. On 12/18/24 at 12: 08 P.M. Corporate Consultant Q reported the hospice company had been contacted and the nurses' notes would be faxed over and could be reviewed in the resident's EMR later that day. The Corporate Consultant indicated all the notes including the nurses should have been placed in the resident's EMR after each visit with R5. On 12/19/24 at 10:00 A.M. the Director of Nursing (DON) was made aware of the concern. The DON was queired concerning communication with hospice staff regarding services provided. The DON indicated staff should be communicating with the hospice staff while on site. The DON was unable to explain how the facility's staff was able to communicate or coordinate any medical concerns when staff did not have access to the nurse's documentation of visits. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Facility's Nursing Agreement dated 11/12/2014, documented under Joint Responsibilities in part: 3.2 Communication and access both parties will allow each other to: 3.2.1 access all records of hospice services rendered to hospice patients and 3.2.2 attend and participate in the other party's interdisciplinary team meeting held for the purpose of developing the plan of care for hospice patients. Clinical Records- Clinical record hospice maintain a complete and timely record on each hospice patient relating to all services rendered. All records of services and treatment are part of the hospice record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on observation, interview and record review the facility failed to ensure enhanced barrier precaution were implemented for two residents (R1 and R9) out of twenty four residents reviewed for infection control, resulting in the potential for the transmission of infectious t organisms. Findings include: R1 On 12/19/2024 at 9:25 AM, Certified Nursing Assistant, (CNA) C, was observed to change the brief and provide other care without wearing Personal Protective Equipment (PPE). On 12/19/24 at12:45 PM, observed Registered Nurse (RN) B and Wound Care Coordinator (WCC) A providing care to R1's stage IV sacral coccyx wound without wearing PPE. According to electronic health record (EHR), R1 was initially admitted on [DATE] with diagnosis of sepsis, bacteriuria, stage IV pressure ulcer, and dementia. R1quarterly Minimum Data Set, (MDS) Assessment with a reference date of 11/5/2024 indicate R1had moderately impaired cognition with a BIMS (brief interview for mental status) score of 6/15. 12/19/24 2:24 PM, Registered Nurse (RN) B, said during an interview that the staff know and understand enhanced barrier precautions, but they do not follow the procedure at the facility. RN B said Enhanced Barrier Precautions are to protect the residents. 12/19/24 2:38 PM, (CNA) C said they only wear PPE when a resident has a sign on the door (R1's door did not have signage). CNA C said they only use the PPE on the unit for diagnosis like clostridium difficile (infection in the stool). 12/20/24 9:03 AM, the Director of Nursing, (DON) said during an interview that staff have been trained but they need to be retrained. The DON said the facility did not want to place a sign on the resident door because of dignity. 12/20/24 9:07 AM, the Nursing Home Administrator, (NHA) said the staff understand that enhanced barrier precautions should be followed on individuals that have any type of opening, and there is no lack of PPE in the facility. 12/20/24 9:22 AM, during an interview WCC A confirmed that the facility did not have an enhanced barrier precautions in place. According to the facility's, 11/1/22 Enhanced Barrier Precautions policy, The facility will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. All staff will receive training on hire and annually. PPE is required when providing high contact care activities. High contact activates were defined as the following: Providing hygiene, changing linen, wound care, device care: urinary catheter, central lines, tracheostomy, and feeding tubes . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	22349 R9: On 12/19/24 at 8:51 AM, Certified Nursing Assistants (CNA)s H and I were observed completing incontinence care for R9. R9 had a PEG (feeding tube). Both CNA H and CNA I put on gloves, but did not put on a gown. Both CNAs were asked about Enhanced Barrier Precautions (EBP). Neither could provide an accurate explanation. Neither could say what PPE (Personnel Protection Equipment) to apply before rendering care. Neither CNA was aware that R9 was on EBP. There was a sign in the hallway that indicated R9 was on EBP. There was a cart in the hallway that had appropriate PPE for staff to use. On 12/19/24 at 9:34 AM, Licensed Practical Nurse (LPN) E administered medications through the residents PEG tube without wearing a gown. LPN E was asked about EBP and appropriate PPE. LPN E was unaware that PPE for residents on EBP included wearing a gown. During in interview on 12/19/24 at 12:03 PM the Director of Nursing (DON) said that staff had been educated on proper use of PPE for residents on EBP. According to R9's Electronic Health Record the resident has resided at the facility since 11/4/14 with diagnoses of stroke, PEG tube, and vascular wounds on the shins. The resident was recently diagnosed with right eye bacterial conjunctivitis.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 22349 Based on interview, and record review the facility failed to maintain a complete and accurate Antibiotic Stewardship Program, resulting in R9's antibiotic usage for an eye infection not being identified, monitored, or administered as prescribed. This deficient practice has the potential to affect all residents receiving antibiotics in the facility. Findings include: On 12/20/24 at 10:40 AM a review of the facility's Infection Control Program was conducted with the Infection Control Nurse, (IFC) D. IFC D said the facility follows McGeer's criteria (a standardized approach to surveillance and reporting of infections) when prescribing antibiotics to review the (antibiotic) usage for accuracy. Residents prescribed antibiotics are documented on the facility's infection report log for monitoring. The IFC nurse said they become aware of residents who are prescribed antibiotics for infections through communications in the facility's daily meetings, infection reports, and a list obtained from pharmacy. During review of the infection report log for November 2024 with IFC D the line listing and infection reports of residents prescribed antibiotics was determined to be incomplete. Resident 9 (R9) was system selected for unnecessary medication review. Review of R9's Electronic Health Record (EHR) revealed the resident had been prescribed Erythromycin ophthalmic solution (antibiotic eye drops) for bacterial conjunctivitis of the right eye on 11/7/24. R9 was not listed on the November infection report. There was no documentation to indicate the IFC nurse was aware the resident had been diagnosed with bacteria conjunctivitis or prescribed antibiotics. On 12/20/24 at approximately 10:45 AM IFC D said, I run a report once a week and there is no evidence this resident (R9) was on an antibiotic. There is no infection report done by the nursing staff. I also use a tracker report to review signs and symptoms of the infections and there is nothing there either. The IFC nurse could not explain how the antibiotic usage was not documented in the facility's infection report or monitored to ensure appropriate antibiotic was prescribed for the recommended length of time. Further review of R9's EHR revealed a progress note dated 11/5/24 at 2:43 PM in part read: Resident was observed with dried, green-tinged drainage from the right eye. The Physician's log was updated and the Infection Control Nurse was notified. On 11/7/24 R9 was prescribed the following: Erythromycin ophthalmic solution to right eye, monitor for adverse side effects for antibiotic therapy of Erythromycin ophthalmic solution for 14 days 11/7/24 - 11/21/24. R9's November 2024 Medication Administration Record (MAR) revealed two separate orders; 1.) Erythromycin ophthalmic solution to right eye (no time frame) and 2.) Monitor for adverse side effects for antibiotic therapy of Erythromycin ophthalmic solution for 14 days 11/7/24 - 11/21/24. The MAR documented that R9 only received two doses of the antibiotic eye drops; 11/7/24 at 9:00 AM and 1:00 PM, and not for the entire 14 days prescribed. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/24 at 11:02 AM, NP G was asked to clarify R9's prescription for antibiotic eye drops. NP G said, The order for the eye drops is 4 times a day and monitor for 14 days. She (R9) was supposed to receive a 14-day course of the antibiotic eye drops and be monitored while getting the eye drops. Not two seperate orders. Why would the eye drops only be for one day and the monitoring be for 14 days? That makes no sense. On 12/20/24 at approximately 11:05 AM IFC D said she had no recall of being notified R9 was prescribed antibiotic eye drops and acknowledged that if the antibiotic prescription would have been on the infection report and line listing there would not have been an administration error. According to the facility's Infection Prevention and Control Program last revised 3/13/24 read in part: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 6. Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. c. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program. d. The Medical Director, consultant pharmacist, and laboratory manager will serve as resources.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on interview and record review, the facility failed to ensure they consistently screened, educated, offered, and administered influenza vaccines for five (R4, R9, R40, R52, and R57) of five residents reviewed for vaccinations/immunizations resulting in R57 consenting to receive the influenza vaccine but not receiving it and the lack of vaccine screening, education, and offering to receive the vaccine for residents R4, R9, R40, and R52. Findings include: On 12/19/24 at approximately 2:00 PM, the five residents (R4, R9, R40, R52, and R57) reviewed for immunizations had no documentation to support they had been screened/assessed, educated on, offered, or administered the influenza vaccine in their Electronic Health Record (EHR). The Infection Control Nurse (IFC) D and the Corporate Clinical Director, Registered Nurse (RN) Q were interviewed at this time. IFC D said the facility used the State of Michigan Influenza Vaccination Assessment and Consent (VAC) form to document and track resident's vaccination status. The forms were kept in a separate binder and not scanned into the resident's Electronic Health Record (EHR) at this time. The binder was retrieved by IFC D and the following documentation was reviewed: R57 IFC D provided a VAC form for R57 dated 10/2/24. The form indicated the resident was screened, was eligible, and consented to receiving the influenza vaccine. The form included the resident's signature and documented the vaccine lot number with the expiration date. The nurse signature line was completed and included a second nurse's co-signature. However there was no documentation to support R57 had received the vaccine. IFC D said the resident received the vaccine. According to the R57's EHR, there was no documentation to support the resident had received the vaccine. There was no physician order for the vaccine and no progress note indicating the resident received the vaccine. The Medication Administration Records (MAR) were reviewed from 10/1/2024 - 12/19/2024 and no administration of the influenza vaccine was recorded. R57's Minimum Data Set (MDS) dated [DATE] indicated the resident admitted to the facility on [DATE] and had a Brief Interview for Mental Status Score of 12/15 indicating moderately impaired cognition status. Both IFC D' and RN Q acknowledged there was no evidence to support R57 received the influenza vaccine at this time. IFC D acknowledged that the facility did have the vaccine available. R4 IFC D provided a VAC form that was incomplete and undated. The assessment/ screening questionnaire on the consent form was crossed out and had no check marks in the boxes to indicate whether the resident had been screened, educated, consented, or declined. There was an undated handwritten note on the bottom of the form that read Declined flu vaccination. The 'nurse signature' section was blank. According to the resident's EHR, R4 has resided in the facility since 2018, was her own responsible party, and had no cognitive impairment. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN Q acknowledged that this immunization/vaccine consent form is incomplete and therefore invalid. R9 IFC D provided a VAC form that indicated the resident had been screened, but no acceptance or declination of the vaccine was marked. The document was incomplete. There was no indication the resident's Legal Guardian (LG) was contacted. The 'nurse signature' section was blank. According to the resident's EHR, R9 has resided in the facility since 2014 with valid LG documents with available contact information. R9 was identified to be nonverbal with severe cognition impairment. It was noted that the resident's LG has signed all other required consents. There was no documentation to support that R9's LG had been educated or offered to provide consent for R9 to receive the influenza vaccines since 12/6/2022. RN Q acknowledged that this immunization/vaccine consent form is incomplete and therefore invalid. IFC D acknowledged that this resident had been missed for immunizations/vaccines this year. R40 IFC D provided a VAC form that was incomplete and undated. The assessment/ screening questionnaire on the consent form was crossed out and had no check marks in the boxes to indicate whether the resident had been screened, educated, consented, or declined. There was an undated handwritten note on the bottom of the form that read Declined flu vaccination. The 'nurse signature' section was blank. According to the resident's EHR, R40 has resided in the facility since 4/17/2023 with valid LG documents and available contact information. There was no documentation to support R40's LG had been educated or offered to provide consent for R40 to receive the influenza immunizations/vaccine. RN Q acknowledged that this immunization/vaccine consent form is incomplete and therefore invalid. R52 IFC D provided a VAC form that was incomplete and undated. The assessment/ screening questionnaire on the consent form was crossed out and had no check marks in the boxes to indicate whether the resident had been screened, educated, consented, or declined. There was an undated handwritten note on the bottom of the form that read Declined flu vaccination. The 'nurse signature' section was blank. According to the resident's EHR, R52 has resided in the facility since 1/11/2021 with a valid LG documents and available contact information. The Minimum Data Set (MDS) dated [DATE] indicated the resident had moderately impaired cognition and the LG had signed all other required consent forms for resident's services at the facility. There was no documentation to support R52's LG had been educated or offered to provide consent for the resident to receive the influenza immunizations/vaccine. RN Q acknowledged that this immunization/vaccine consent form is incomplete and therefore invalid. According to the facility's Infection Prevention and Control Program last revised 3/13/24 read in part: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 7. Influenza and Pneumococcal Immunization: a. Residents will be offered the influenza vaccine each year between October 1 and March 31. unless contraindicated or received the vaccine elsewhere during that time. b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere. c. Education will be provided to the residents and or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. d. Residents will have the opportunity to refuse the immunizations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235234	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Nursing and Rehab Center	9500 Grand River Ave Detroit, MI 48204

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 15194 Based on observation, interview and record review the facility failed to ensure residents call lights were properly functioning for one of four units, resulting in a potential for a delay in responding to care needs of the residents that resided on the unit. Findings include: On 12/17/24 at 10:30 A.M. during an observation on the third floor. Residents were observed with assorted bells in their rooms. During the observation the residents were queired concerning the use of the bells. R47 who was alert and oriented indicated he was not sure where the bell was but when he needed a nurse he went to the nursing station. R47's roommate interjected and stated residents on the unit were given the bells because the call lights were not working, and residents were told to use them when they needed help. R35 indicated sometimes the nurses might be down the hall and could not hear the bell. According to R35 sometimes you can ask someone to tell the nurses you need help. On 12/19/24 at 12:05 P.M., Director of Maintenance (DM) K was interviewed concerning the replacement of the call lights and how many residents were affected. (DM) K reported initially it was only a few residents with bells, but an irate resident hit the main box at the nursing station and after that incident the call light system did not work properly. (DM) K reported the residents had been using the bells for about 3 weeks but the facility had obtained information concerning replacing the call light system on the third floor. A request was made to review the information. At 12/19/24 at 1:30 P.M. an undated estimated invoice was presented. The invoice described a proposal to update the existing nurse's call system on the third floor, which included all aspects of wiring on the unit including individual wiring of resident's room etc. The undated estimate was not signed. There was no evidence of a contract for work to be initiated or completed by the facility or corporate office. (DM) K indicated the current estimate was the only estimate of repair. On 12/20/24 at 2:00.P.M. the Administrator indicated the third floor was the last floor to be renovated however, no additional information (plans, quotes) was provided as to how long the renovation was projected to take before completion or started.

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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** 15194 This citation has two deficient practice statements. Deficient Practice #1 Based on observation and interview the facility failed to effectively clean and maintain the physical facility in good repair affecting 25 residents on the third floor, resulting in an unpleasant, non-homelike environment. Findings include: On 12/17/24 at 10:30 a.m. during an observation of the third-floor unit the floor tiles, walls, and base boards were observed to need deep cleaning. Floor tiles were observed cracked, chipped and needed to be replaced. Rooms were noted with cracked, missing floor tiles, broken resident equipment. The unit had a malodorous smell that lingered. Other concerns noted on the unit included: 1. Aluminum tape surrounding the air conditioning units were detached from the unit allowing air, gaping holes and visibility to the outside. 2. Floors in the hallway and resident's rooms had visible collection of dirt, food particles, dust and soiled areas around the base boards and perimeters of the floors. Floors were noted with broken, missing, soiled floor tiles in rooms 307, 312, 314 and 318. Bedside tables, walls and furniture in the common areas were scratched, soiled and needed to be replaced. A broken television was stored on the floor in the resident's lounge on the unit. 3. Broken hand sanitizer dispensers were noted in rooms [ROOM NUMBERS]. 4. Slots in the window blinds were missing, in room [ROOM NUMBER] and 318. 5. Resident's personal clothing's in room [ROOM NUMBER] were stored on the floor among food from outside and opened cans of soda pop. 6. Rusted, broken bed frames were observed in rooms [ROOM NUMBERS]. 7. Privacy curtains in room [ROOM NUMBER] had old stains and were detached from the curtain rod. 8. Floors, in the hallway and resident's room needed deep cleaning. walls in resident's rooms and hallway needed to be painted. Floors and walls were observed scratched with broken plaster and door frames. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 3:30 P.M., an interview with the Housekeeping/Laundry Director L concerning the cleaning of the unit, painting of the walls, floors and soiled areas of the floor was conducted. The Housekeeping/Laundry Director indicated one person was assigned to buff and wax the floors three times a week, but that person was recently hired. There was a cleaning schedule, and staff was assigned daily however there was no evidence or monitoring by management. Director L indicated staff cleaned the floors but the tiles needed replacing and no matter how much cleaning was performed cleaning could not remove the soiled areas embedded in the tile floors. Director L acknowledged the base boards of the rooms on the third floor were not done since the third floor was the last floor to be renovated. In a follow-up interview with Environmental Director J. The Environmental Director 'J' indicated the third floor was scheduled to be renovated and it was the last unit scheduled however the time frame was unknown. Upon exiting the facility on 12/20/24 at 2:00 P.M. no additional information was provided related to the physical environment on the third floor. 47964 Based on observations, interviews, and record reviews the facility failed to effectively clean and maintain the physical plant affecting the fifth-floor and second-floor residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include: On 12/19/24 at 9:55 AM the Director of Maintenance (DOM) K was interviewed and said maintenance completed ongoing monthly checklists for environmental and maintenance concerns. On 12/19/24 at 10:00 AM a fifth-floor environmental tour was conducted with the DOM K and the Regional Director of Maintenance (RDM) J. The following items were noted: -Elevator number two had lights not working and the light grates were soiled. -On the fifth floor directly across from the elevators observed a strong urine odor with the baseboard stained dark yellow/brown in color. -The fifth-floor hallways paint appeared dingy with multiple scratches. The (RDM) J said the fifth-floor walls should be painted as part of the overall repair process. -The fifth-floor day room had two chairs with ripped seat covers. - Fifth-floor residents R85 and R15 had damaged wheelchairs which included missing arm rests, torn wheelchair back. Record review of the Maintenance checklist from October to December 2024 revealed no specific entries related to the maintenance concerns. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 4:00 PM the Nursing Home Administrator (NHA) was interviewed and agreed cleaning and maintenance was an ongoing process and the above listed items should be repaired and or cleaned.