STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235237	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calhoun County Medical Care Facility	1150 E Michigan Ave Battle Creek, MI 49014

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on interview and record review the facility failed to perform a Minimum Data Set (MDS) significant change in condition assessment for one of 19 residents (Resident #87) resulting in the potential for care needs to be unmet. Findings Included: Per the facility census R87 was admitted to the facility on [DATE]. Review of a, Supportive Care Goals Worksheet document dated 1/21/2025, revealed 87's family consented for R87 to have no measures to sustain life, a do not resuscitate (DNR) order, no hospitalization , no routine testing, no routine weights, only essential medication and vital signs were to be given. At the bottom of the form under Supportive Care it was revealed that 87's authorized decision maker signed the form on 1/21/2025 stating that consent was given for Supportive Care, and to provide treatments to promote quality of life and comfort, rather that achieve improvement in health for R87. The Nurse Practitioner signed the form on 1/21/2025, and the Physician signed the form on 1/24/2025. Review of a, Statement of Likely Terminal Illness revealed R87 was determined on 1/29/2025 to have deterioration of health or natural death may occur within six months. The document was signed by the Physician eight days after the family consented to 87's supportive care. Review of a Change in Condition (not a significant change in condition MDS assessment) assessment dated [DATE], revealed R87 had a decrease in responsiveness, weakness, swallowing difficulty, when stimulated R87's breathing would get louder, moaning with repositioning, and not respond to stimulation. The assessment revealed that R87 would transition to Comfort Care. In an interview on 2/21/2025 at 12:14 PM, Registered Nurse (RN) L RN, who was the MDS nurse, stated that she did do a significant change MDS assessment in October of 2024, and said the assessment was conducted because R87 had transitioned to Supportive Care. The last significant change MDS assessment was completed October 14 2024. Under Section J1400. of the October 2024 assessment, revealed, Prognosis. Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? . there was no check mark. R87 was not placed on supportive care until 1/21/2025. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/21/2025 at 1:10 PM, Director of Nursing (DON) B stated that Supportive Care was to provide the resident with all their wants and wishes. DON B said the resident would have no more hospitalization s, would become a DNR, would have no more blood drawn for laboratory testing. DON B said when the resident would have more changes that show end of life, the family would be encouraged to be around the resident more, comfort care would be provided, and what ever the resident needs and wants were would be provided. No significant change MDS assessment was completed for R87 as a result of R87's transition to Supportive Care, identification of a terminal illness with a life expectancy of less than six months to live.

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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** 27446 Based on observation, interview, and record review the facility failed to ensure three out of 19 residents (Resident 26, 57, and 87) received care and services that met their care needs resulting in the potential for unmet care needs. Findings Included: Resident #87 (R87): Per the facility census R87 was admitted to the facility on [DATE]. During the entrance conference on 2/18/2025 at 10:04 AM Administrator A stated that the facility did not offer outside contracted Hospice services, but did offer services provided by the facility to residents. Review of the facility, Supportive Care Protocol policy dated 12/20/2022 and revised on 5/10/2023, revealed that the facility provided, .comfort, dignity, and support, as residents enter the last stages of their life. The policy revealed, This will allow the resident to focus their goals of care to support how they (the resident) choose to live rather than try to cure or aggressively treat their chronic health conditions. Further review of the policy revealed under POLICY INTERPRETATION & IMPLEMENTATION:, I. Clinical Dementia scale assessment and a Palliative Performance Scale assessment will be completed by an MDS (Minimum Data Set) nurse. The scoring of these assessments tools will be utilized by the interdisciplinary team (IDT) along with the resident's clinical signs and symptoms indicating a general decline. Under II. If the resident meets the criteria for Supportive Care (a terminal stage less than 6 months of life) by the IDT or the family members/resident's request, a care conference will be scheduled ASAP (as soon as possible) to discuss the resident's goals of care., A Statement of Likely Terminal Illness will be initiated by the NP (Nurse Practitioner) or designee, and then approved by the physician when deemed appropriate to do so. Review of a, Supportive Care Goals Worksheet document dated 1/21/2025, revealed 81's family consented for R87 to have no measures to sustain life, a do not resuscitate (DNR) order, no hospitalization , no routine testing, no routine weights, only essential medication and vital signs were to be given. At the bottom of the form under Supportive Care it was revealed that R87's authorized decision maker signed the form on 1/21/2025 stating that consent was given for Supportive Care, and to provide treatments to promote quality of life and comfort, rather that achieve improvement in health for R87. The Nurse Practitioner signed the form on 1/21/2025, and the Physician signed the form on 1/24/2025. Review of an IDT care conference dated 1/21/2025, revealed R87's decision maker was present at the meeting, and supportive care was discussed. No other IDT care conference was documented in R87's electronic medical record (EMR). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a, Statement of Likely Terminal Illness revealed R87 was determined on 1/29/2025 to have deterioration of health or natural death may occur within six months. The document was signed by the Physician eight days after the family consented to R87's supportive care. Review of Physician's orders dated active as of 2/4/2025, revealed R87 still had laboratory orders in place for annual complete blood count (CBC), comprehensive metabolic panel (CMP), lipid panel, thyroid screen, C-reactive protein (measures inflammation) that were ordered on 1/2/2025, and had not been discontinued per R87's family supportive care decision as outlined on the Supportive Care Goals Worksheet. The orders all revealed these were active orders. The orders also revealed R87 had an order that was still active as of 1/2/2025, and not discontinued, to obtain a weight every month. Review of R87's weight log revealed R87 continued to be weighed by staff after 1/21/2025 when R87 was placed on Supportive Care, and weighing R87 was discontinued. R87 was weighed on 1/23, 2/7, and 2/12/2025. Review of the facility policy titled, End of life Care Protocol dated 11/24/2000, last revised on 5/10/2023, and last reviewed on 12/27/2024, revealed that it was the policy of the facility to provide comfort, dignity and support, during the dying process. The policy revealed, This End of Life process will be known as Comfort Care. Review of a Change in Condition assessment dated [DATE], revealed R87 had a decrease in responsiveness, weakness, swallowing difficulty, when stimulated R87's breathing would get louder, moaning with repositioning, and not respond to stimulation. The assessment revealed that R87 would transition to Comfort Care. In an interview on 2/20/2025 at 11:12 AM, Staff Educator (SE) G stated that she provided end of life training for the staff on Supportive and End of Life Care with a power point presentation. SE G said Supportive Care is provided when a resident is determined to have six months or less to live, and Comfort Care or End of Life is when a resident is determined to have days to weeks to live, and actively dying. Review of the power point presentation SE G provided as the educational tool used to train staff revealed, no date of the creation of the educational power point presentation in order to determine current standards of practice, and no references to educational content to validate facts and best practices for end of life care (Palliative, Supportive, Comfort, End of Live Care). The education tool did not specify how a resident who receives these services, in regards to Supportive Care and End of Life Care, has an increase in care needs, nor how to provide for the resident and family those extra care needs. The education power point tool focused mostly on the symptoms a resident will show once in the active dying stage. In an interview on 2/20/25 at 3:34 PM, with CNA I and CNA J both stated that when a resident had six months to live that meant they could give the resident whatever the resident wanted. Both CNAs said they did receive the power point training which was from SE G, and said every year they have to review the training. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a continued interview with CNA I and J both CNAs stated that they did not provide any additional care to residents who receive Supportive or End of Life Care, and both agreed that they have not been told or trained that they are to provide any other extra care, that was more than the care they already provided. In an interview on 2/21/2025 at 1:10 PM, Director of Nursing (DON) B stated that Supportive Care was to provide the resident with all their wants and wishes. DON B said the resident would have no more hospitalization s, would become a DNR, would have no more blood drawn for laboratory testing. DON B said when the resident would have more changes that show end of life, the family would be encouraged to be around the resident more, comfort care would be provided, and what ever the resident needs and wants were would be provided. 45038 Resident #26 (R26) Review of the medical record demonstrated R26 was admitted to the facility 01/19/2024 with diagnose that included chronic respiratory failure, venous insufficiency (improper functioning of the vein valves in the leg), peripheral vascular disease (PVD), Alzheimer's disease, dementia, hypertension, morbid obesity, congestive heart failure (CHF), type 2 diabetes, stage 3 kidney disease, obstructive sleep apnea, blepharoconjunctivitis (inflammation of both the eyelids and the conjunctiva), bilateral cataracts, chronic pain, gastro-esophageal reflux, hypothyroidism (low thyroid hormone), constipation, intellectual disabilities, and mental and behavioral disorder. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/2024 demonstrated a Brief Interview for Mental Status (BIMS) of 00 (most server level of cognitive impairment) out of 15. During observation and attempted interview on 02/18/2025 at 11:47 a.m. R26 was observed sitting up in a wheelchair in his room. R26 did not answer questions. R26 left lower eye lid was observed to be red and drooping. Review of R26 medical record did not demonstrate any change of condition assessment or clinical documentation demonstrating observation of conjunctivas (redness/swelling of lower eye lid) for R26. Review of physician orders and plan of care did not demonstrate any treatment for conjunctivas. In an interview on 02/20/2025 at 10:50 a.m. Licensed Practical Nurse (LPN) D explained that R26 had a history of blepharoconjunctivitis (inflammation of both the eyelids and the conjunctiva). LPN D explained that she recently had observed that R26 currently had a dropping, red, and swollen left lower eye lid but that she had not written a condition change or called the physician for orders in the treatment of R26 lower eye lid. LPN D explained that she would notify the physician and document any orders as given. During observation and interview on 02/21/2025 at 09:35 a.m. R26 was observed sitting up in his wheelchair in his room. It was also observed that R26 had visible matting on bilateral eye lashes and redness and swelling was visible on his lower eyelid. When asked if R26 eyes itched or/and were painful he responded yes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R26 medical record after the above observation still did not demonstrate any documentation of a change of condition or documentation of R26 matted bilateral upper eyelids or his red lower eyelid. R26 medical record did not demonstrate any orders for observation or treatment of the matting or treatment for the redness of his lower eye lids. In an interview on 02/21/2025 at 09:35 a.m. Director of Nursing (DON) B explained that it was her expectation that if a resident experienced a change in medical condition the nurse would notify the residents physician, the family, the Nursing Home Administrator, and the Director of Nursing or Assistant Director of Nursing. DON B confirmed that R26's record did not contain any information demonstrating an assessment of R26 lower left eye lid or any orders for treatment to date as of 02/18/2025. DON B could not explain why documentation of a condition change had been completed since the Licensed Practical Nurse was aware of R26 possible left eye conjunctivitis. 34705 Resident #57 (R57) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R57 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure, congestive heart failure(CHF), chronic obstructive pulmonary disease, history of lung cancer with lung removal, diabetes mellitus, history pneumonia, anxiety and depression. The MDS reflected R57 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required set up dressing, hygiene; supervision with bathing and toileting; and partial/moderate assist with transfers. During an observation and interview on 2/18/25 at 10:07 a.m., R57 in room sitting upright in recliner and appeared able to answer questions without difficulty. R57 reported was taking long acting insulin daily and staff were not monitoring blood sugars. Review of R57 physician orders, dated 2/7/25, reflected Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 20 unit subcutaneously one time a day for DM[diabetes mellitus]. Continued review of R57 Physician Order, dated 11/5/24 through 2/6/25, reflected, Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 15 unit subcutaneously one time a day for Steroid induced DM. Review of Physician order, dated 10/16/24 through 1/30/25, reflected, Admelog Injection Solution 100 UNIT/ML (Insulin Lispro) [fast acting insulin] Inject as per sliding scale .subcutaneously before meals for hyperglycemia. Review of the Medication Administration Record, date 1/1/25 through 1/31/25, reflected R57 blood sugars, were monitored three times daily and ranged from 72 to 353. R57 required use of fast acting insulin via sliding scale on 25 occasions in month of January. Review of R57 Electronic Medical Record(EMR), dated 1/31/25 through 2/18/25, reflected no evidence R57 blood sugar was monitored. Review of R57 Physician Orders, dated 2/1/25 through 2/18/25, reflected R57 had physician orders for two prophylactic antibiotics and daily steroids for chronic respiratory condition. (These types of medications known to cause increased blood sugar). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R57 Dietary Note, dated 1/30/2025 at 12:09 p.m., reflected, Quarterly nutrition assessment completed. Regular diet with thin liquids. Tolerating current diet texture well at this time .Significant weight gain x 3 months. Weight trend: 176# (1/18/25), 172# (12/18/24), 161# (10/16/24), and 166# (7/18/24). Resident remains at risk for weight fluctuations due to diagnosis of CHF with diuretic use .12/3/24 labs: Glucose 106 .HA1c[test to monitor blood sugar over past two to three months] 7.6%[normal level below 5. 7%]. Sliding scale insulin in place to help prevent hyperglycemia. Resident is on a steroid which likely impacts blood glucose levels. Will follow up and update residents meal preferences as needed. Will follow weight trend. Continue current nutrition POC. Follow up as needed. Review of R57 Physician Progress Note, dated 2/6/25, reflected, Patient has increasing heartburn. Omeprozole will be added patient is on chronic steroid use and NSAID[class of medications for heartburn] sometimes and also i will increase lantus to 20 units once a day from 15 units. accu-check[method to monitor blood sugar] will be monitored. (Review of the EMR reflected no evidence of blood sugar monitoring.) During an interview on 2/21/25 at 11:19 AM, Licensed Practical Nurse(LPN) H verified R57 received Balsagar long acting insulin daily that was recently increase related to elevated blood sugars on 2/7/25 and R57 did not have physician order for blood sugar monitoring. LPN H reported after review of R57 EMR, reported last recorded blood sugar was 1/30/25. LPN H reported residents on insulin usually have a physician order for blood sugar. During an interview on 2/21/25 at 1:54 PM, Director of Nursing(DON) B reported would expect staff to follow physician orders including orders to monitor blood sugar. DON B reported reviewed R57 orders and reported appeared to be transcription error and R57 should have had a physician order to monitored blood sugar.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to ensure proper storage, cleaning and labeling of oxygen/respiratory equipment for two Resident (R57 and R61), of four residents reviewed for oxygen and respiratory care, resulting in the likelihood for cross contamination, respiratory illnesses/disease. Findings include: Resident #57(R57) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R57 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure, congestive heart failure(CHF), chronic obstructive pulmonary disease, history of lung cancer with lung removal, diabetes mellitus, history pneumonia, anxiety and depression. The MDS reflected R57 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required set up dressing, hygiene; supervision with bathing and toileting; and partial/moderate assist with transfers. During an observation and interview on 2/18/25 at 10:07 a.m., R57 was in room sitting upright in recliner(no bed in R57 room) with oxygen in use via nasal cannula set at 3 liters per minute with tubing dated 2/10/25. R57 had nebulizer equipment including mask that was un-bagged/undated on bedside table and Continuous positive airway pressure(CPAP) machine on dresser un-bagged. R57 appeared able to answer questions without difficulty. R57 reported long history of respiratory issues including right lobecomy related to cancer and several episodes of pneumonia with hospital admissions. R57 reported used CPAP nightly and staff add water to chamber but do not rinse or clean mask and reported prior to admission to facility rinsed mask daily at home. During an interview on 2/21/25 at 11:19 AM, Licensed Practical Nurse(LPN) H reported oxygen tubing was changed weekly, every Monday, and nebulizer equipment was not reused. LPN H reported CPAP equipment and un-used oxygen tubing was stored in black cloth bags and changed monthly. Resident #61(R61) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R61 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, diabetes mellitus, dementia and manic depression. The MDS reflected R61 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. During an observation and interview on 2/18/25 at 11:31 AM, R61 was sitting in chair in room with oxygen running via nasal cannula. R61 appeared pleasant and able to answer questions without difficulty. Observed R61 Bilevel Positive Airway Pressure(BiPAP) equipment in room with mask resting directly on bed. R61 reported staff fill water chamber and connect oxygen but do not rinse mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/25 at 12:05 p.m., LPN H reported if residents had CPAP or BiPAP they usually had orders to clean masks weekly in Treatment Administration Record(TAR) and verified R57 or R61 did not have orders to clean CPAP/BIPAP and was unsure why. LPN H verified R61 had respiratory mask laying directly on bed and did not have black bag available in room for storage. During an observation on 2/21/25 at 12:15 PM, R57 was sitting in recliner in room with oxygen running via nasal cannula from room concentrator with tubing dated 2/10 (11 days old). During an interview on 2/21/25 at 1:54 PM, Director of Nursing(DON) B reported would expect CPAP/BiPAP equipment to be stored in black bags and orders in Treatment Administration Record for nurse to clean weekly. DON B reported would expect oxygen tubing to be changed weekly.

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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** 34705 Based on observation, interview, and record review the facility failed to insure that one resident (R57) was free from significant medications errors out of one resident reviewed for significant medication errors resulting in the potential for adverse physical reactions/outcomes to residents. Findings Included: Resident #57 (R57) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R57 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure, congestive heart failure(CHF), chronic obstructive pulmonary disease, history of lung cancer with lung removal, diabetes mellitus, history pneumonia, anxiety and depression. The MDS reflected R57 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required set up dressing, hygiene; supervision with bathing and toileting; and partial/moderate assist with transfers. During an observation and interview on 2/18/25 at 10:07 a.m., R57 in room sitting upright in recliner and appeared able to answer questions without difficulty. R57 reported had concern about medications related to medication error that occurred on 2/15/25 afternoon shift. R57 reported had been sleeping and was waken by male nurse who who administered medications and later came in and apologized after reporting had administered R57 another residents medications. R57 reported staff informed R57 that Nurse Practitioner had been notified who said R57 would be okay. R57 stated, I felt fuzzy the next day. R57 reported staff did not follow up with her after medication error and reported usually reviews her medications but had been sleeping that day. Review of R57 Nurse Progress Note, dated 2/15/2025 at 10:44 p.m., reflected, Patient given Percocet[controlled narcotic] 10-325mg, Atorvastatin[used to treat high cholesterol] 40mg, Gabapentin[used to treat seizure disorder or nerve pain] 300mg given in error. No adverse effects noted during this time. [Named Assistant Director of Nursing(ADON) N, Nurse Practitioner(NP) O, and Nursing Home Administrator(NHA) A] all notified of the event at 19:50[7:50 p.m.]. Medication error form was completed. BP: 143/76 R: 16 P: 74 O2: 97% Resident is alert and oriented. Review of R57 Medication Administration Record(MAR), dated 2/1/25 through 2/20/25, reflected R57 was administered Hydrocod [NAME]-Chlorphe [NAME] ER Oral Suspension Extended Release 10-8 MG/5ML (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give 5 ml by mouth as needed for cough on 2/16/25 at 1:03 a.m.(cough syrup with codeine, controlled narcotic, five hours after given Percocet 10mg((controlled narcotic)) R57 was not prescribed, in error). Review of the facility, MEDICATION AND TREATMENT ERRORS AND OMISSIONS, dated 2/15/25 at 7:30 p.m., reflected R57 received another resident medications in error that included Percocet 10/325mg, Atrovastatin 40mg, and Gabapentin 300mg. The document included description, [named LPN Q] pulled meds to pass, I thought she instructed me to take them to [named R57], but they were intended for [named other Resident S]. Review of the facility, CONTROLLED DRUG RECEIPT/RECORD/DISPOSITION FORM, dated 2/15/25 through 2/20/25, reflected LPN Q signed out Percocet 10/325mg for other resident S at 7:29 p.m. The record reflected hand written note on document by same entry, med error, given to another res. During a telephone interview on 2/20/25 at 3:00 PM, Licensed Practical Nurse(LPN) P reported had worked at the facility for three weeks and was currently still with preceptor. LPN P reported worked 2/15/25 night shift from 7:00 p.m. to 7:00 a.m. with preceptor LPN R. LPN P reported received report from day nurse LPN Q. LPN P reported preceptor LPN R stepped away and while waiting for LPN R to return, day nurse LPN Q asked LPN trainee P to deliver prepared medications to R57. LPN R reported must have misunderstood day nurse LPN Q because he thought LPN Q said R57 first name but actually medications were for another resident S with similar name. LPN P reported discovered about 10 minutes later after day nurse LPN Q had left the facility. LPN P reported assessed R57, informed of the medication error, completed paperwork, informed Nurse Practitioner (NP) O and Assistant Director of Nursing (ADON) N. LPN P reported NP O ordered to hold xanax, ibuprofen and R57 lesser dose of Atrovastatin. LPN P verified R57 was given Percocet 10/325mg(controlled narcotic pain medication), Atrovastatin 40mg, Gabapentin 300mg in error. LPN P reported monitored R57 through out night, however, was unsure if assessments had been documented with exception of vitals at the time of the medication error. LPN P reported R57 complained of feeling hazy in morning and was unsure if that was documented. LPN P reported had not worked since event and reported after the medication error Preceptor LPN R educated LPN P not to pass resident medications prepared by another staff. During a telephone interview on 2/20/25 at 3:32 PM, LPN Q reported had worked at the facility for about three months and was a new nurse. LPN Q reported had worked 2/15/25 on day shift and given to report to LPN R and Trainee LPN P around 7:00 p.m. and reported that another resident needed pain medications. LPN Q reported did not recall asking Trainee LPN P to pass medications she had prepared. LPN Q reported if she had prepared controlled narcotic medications they would be signed out by her on the, Controlled Drug Record. LPN Q reported received call from Director of Nursing(DON) B that day(2/20/25) about R57 medication error and reported was not aware of medication error until today. LPN Q reported had not yet received education related to incident. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 2/20/25 at 4:02 pm, Preceptor LPN R reported had worked at the facility about 3 months and was a new nurse. LPN R reported was LPN P preceptor on 2/15/25 for first time. LPN R reported was not asked prior to having to mentor new staff but felt comfortable. LPN R reported received report from LPN Q, who was behind and finishing medication pass at shift change. LPN R reported LPN Q prepped another resident medications and informed LPN R resident had also requested hair and tooth brush. LPN R reported she went to obtain items and returned to medication cart less than five minutes later and LPN Q was gone and Trainee LPN P reported LPN Q told him to administered prepared medications to R57. LPN R verified another resident medications had been given to R57 in error. LPN R reported medication error to Assistant Director of Nursing (ADON) N, NP O and R57 and orders were obtained to hold three of R57 own medications. LPN R reported monitored R57 and completed medication error report and reported unsure if R57 monitoring was documented. LPN R reported R57 did report she felt fuzzy to LPN P in the morning and was unaware of documented or reported to provider. LPN R reported, new nurses usually work seven shifts with preceptors. LPN R stated she did educated LPN P not to administer medications prepared by someone else. During an interview and record review on 2/21/25 at 1:02 PM, -02/21/25 01:50 PM, Staff Educator Registered Nurse G reported had been staff educator for five years. RN G reported new hire nurse staff received one to two day classroom orientation then received training with preceptor on floor for several shifts depending on skill level. RN G reported preceptors receive training on how to train prior to being asked to be preceptor. RN G reported schedules are completed by facility scheduler along with DON B and RN G was not involved. RN G reported LPN R had not been trained to be a trainer and had not been asked prior to shift if she could be preceptor. LPN G reviewed the 2/15/25 schedule and reported there was a more seasoned nurse on night shift who would have been qualified and trained to be LPN P preceptor. RN G reported would expect nurse who prepared medication to administer medications especially controlled narcotic medications. During an interview on 2/21/25 at 1:54 PM, Director of Nursing(DON) B reported was made aware of R57 medication administration error on 2/17/25 and ADON N was notified shortly after incident. DON B reported called individuals involved and reported Trainee LPN P was working with LPN R on 2/15/25 7:00 p.m. to 7:00 a.m. shift with LPN Q on day shift 2/15/25. DON B reported LPN Q prepped medications and asked LPN P to administer to another resident but LPN P heard R57. DON B reported would expect nurse who prepares medication to administer medications. DON B reported staff schedule completed by scheduler and Staff Educator G during training and reported DON B was not involved in scheduling new staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 34705 Based observation, interview, and record review the facility failed to ensure proper storage of medication in three of three medication carts and one medication room of three reviewed for medication storage. Findings include: During an observation and interview on 2/20/25 at 7:57 a.m., Registered Nurse (RN) T opened the Maple Grove Medication cart. RN T verified three opened undated eye drops including xalatin, cosopt, and alphagan. RN T reported should be dated when opened and reported some staff document items open date in binder on medication cart and verified was not documented. During an observation on 2/20/25 at 8:51 AM, Licensed Practical Nurse (LPN) U opened the [NAME] Court Medication cart. LPN U verified open undated eye drop prednisolone Acetate Ophthalmic Suspension 1 % and was unsure when it had been opened. During an interview on 2/21/25 at about 3:30 PM, Director of Nursing(DON) B reported would expect multidose medications including eye drops to be dated when opened and staff to follow, Medication with Shortened Expiration dates, guide placed in medication cart binders yesterday. DON B reported staff were educated on process starting yesterday. 49272 During an observation and interview on 2/20/25 at 10:51 AM, Licensed Practical Nurse (LPN) H opened the Red Oak Trail Medication cart. LPN H verified two opened undated eye drops including Brimonidine 0.2% and Latanoprost 0.005%. LPN H reported eye drops should be dated when opened. During an observation and interview on 2/20/25 at 11:19 AM, with LPN H the medication room on Red Oak Trail was reviewed, inside of an unlocked cupboard the following expired medications were found: an opened tube of triple antibiotic ointment labeled with a residents first initial and last name with a manufactures expiration date of 12/19, an opened tube of triamcinolone 0.1% ointment labeled with a residents first initial and last name with a manufactures expiration date of 12/13 and a bottle of carbamide peroxide ear drops with a manufactures expiration date of 7/24. When asked how expired medications should be handled, LPN H reported that they should be discarded. Review of the facilities policy titled Storage and Labeling of Drugs and Biologicals updated 12/30/24, documented in part All drugs must have an expiration date on the manufacture's container and will not be kept beyond this identified date .Specific medications such as insulins, ophthalmics and inhaler, for example, with shortened expiration dates once the medication is opened, will be dated when opened and will be discarded according to specific pharmaceutical guidelines .

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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** 38905 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During an evaluation of the kitchen, at 10:02 AM on 2/18/2025, it was observed that clear plastic scoops of the bulk storage containers were found hanging on the outside perimeter of the containers facing where staff would walk by. Observation found two of the scoops with discolored dingy surfaces. When asked if the scoops are normally stored open exposed on the front of the bin about a foot or so off the ground, Certified Dietary Manager (CDM) K stated that's where they have been kept. Further observation found that neither of the three containers were labeled with the common name of the ingredients they contained. According to the 2022 FDA Food Code section 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the FOOD with their handles above the top of the FOOD and the container .(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not time/temperature control for safety food . During a tour of the main kitchen, at 10:22 AM on 2/18/2025, it was observed that the two compartment preparation sink was found directly connected to the waste water line. When asked if there was a basement under the kitchen, staff were unsure and were not aware of the drain having an air gap. When asked what the sink is used for, CDM stated staff use the sink for food preparation. During a tour of the Beachwood kitchenette, at 1:24 PM on 2/18/2025, it was found that the overhead dish spray was observed hanging below the overflow rim of the sink. It was also observed that the small two compartment sink, had a sink sprayer on the back side of the sink that could be pulled out and lay below the overflow rim of the sink. These plumbing set ups create the potential for cross connections between potable water and wastewater. During an interview with Facilities Operations Manager M at 1:55 PM on 2/20/2025, it was found that there is no basement under the kitchen and that all plumbing is in the floor indicating an air gap would not be present. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed . According to the 2022 FDA Food Code section 5-202.13 Backflow Prevention, Air Gap. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonFOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). During a tour of the main kitchen, at 10:21 AM on 2/18/2025, it was observed that a container of germicidal wipes was present on the three-compartment sink. The manufactures label stated the product was a high-level disinfectant and a further review of the label found it was not approved for food contact surfaces. When asked what staff use these wipes for, CDM K stated she doesn't think they use the wipes and are not sure why the container was stored there. During a tour of the janitors closet of the main kitchen, at 11:04 AM on 2/18/2025, it was observed that an open bottle of chemical (Spic and Span) was observed with no cap sealing the container. According to the 2022 FDA Food Code section 7-204.11 Sanitizers, Criteria. Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACEs shall: (A) Meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (Food-contact surface sanitizing solutions)P, or (B) Meet the requirements as specified in 40 CFR 180.2020 Pesticide Chemicals Not Requiring a Tolerance or Exemption from Tolerance-Non-food determinations. During an initial tour of the facility, the following areas were observed to have an excess accumulation of debris: under the racks of the walk-in cooler floor, structural portions of the ventilation hood in the main kitchen, and behind the oven in the Red Oak kitchenette. When asked about the accumulation behind the oven on Red Oaks, CDM K stated that it's on our list to get done. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . 49272 During a tour of the kitchen, at 10:35 AM on 2/18/25, an interview with CDM K found that the facility does not regularly test their sanitizer buckets. When asked about the availability of test strips, it was found that the only test strips available had manufacture expiration date of [DATE]. Further review found that the test strips were for bleach based sanitizer and the facility uses quaternary ammonium. According to the 2022 FDA Food Code section 4-302.14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided. During an evaluation of the kitchen, at 11:00 AM on 2/18/25, an interview with CDM K found that the large floor mixer is used approximately five times per week. At this time, the mixer was observed to have dried, white, food debris on the grated splash guard and the mixer was not in use. During an evaluation of the kitchen, at 11:10 AM on 2/18/25, the meat slicer was observed to have an accumulation of dried food debris in the back under side portion of the blade. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an evaluation of the satellite kitchen in the [NAME] hall, at 12:04 PM on 2/18/25, the ice dispenser was observed to have a buildup of an orange substance inside the shoot. During an evaluation of the satellite kitchen on the Red Oak hallway, at 12:49 PM on 2/18/25, it was observed that the ice dispenser shown a buildup of an orange substance inside the dispensing shoot. During an evaluation of the satellite kitchen on the Blue Spruce hallway, at 1:04 PM on 2/18/25, the ice dispenser was observed to have a buildup of an orange substance inside the dispensing shoot. During an evaluation of the satellite kitchen on the Beechwood Hill hallway, at 1:24 PM on 2/18/25, the ice dispenser was observed to have a buildup of an orange substance inside the dispensing shoot. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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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** 38905 Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During an interview with Facilities Operations Manager (FOM) M, starting at 10:23 AM on 2/20/25, it was found that the facility does not currently have any routine testing on the facilities water supply. When asked if there was a team that oversaw the Water Management Program (WMP), FOM M stated she was unsure of a team. When asked what facility established control limits were in place in order to decrease the risk of Legionella and OPPP from growing a spreading in the facility, FOM M was unsure and stated she was slightly newer to the position and had not had much to do with WMP before. During a tour of the facility, with FOM M, starting at 10:53 AM on 2/20/25, the following water fixtures were identified as having an increased risk of developing OPPP / Legionella: A review of [NAME] Ridge soiled utility room hopper found discolored water momentarily dispensed from the faucet over the hopper. A review of the Red Oak janitors closet found the cold-water line was shut off and a sewer gas odor was present with air coming from the drain for the Janitors sink. This indicates that faucet has not been used in so long that the p-trap for the wastewater line has evaporated. A review of the Maple soiled utility room hopper found that brown and discolored water ran from the faucet above the hopper for roughly 10 seconds before becoming clear. When asked if she could see the discolored brown water, FOM M stated yes. Further review found that the foot pedals to the hopper spray were found turned off, creating a stagnant line. A review of the upstairs Service Hall found a large commercial humidifier attached to the water line that was left on. When asked if the facility uses the humidifier, FOM M stated no, it's been down for as long as she knows. A review of the Beachwood soiled utility hopper found that dark brown water dispensed from the hot water supply for roughly seven seconds. (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 facilities policy entitled, Water Management Program - Legionella, revised 1/12/24, found that under the Preventative Maintenance heading, it states System Flushing - Flush all drain outlets (both hot and cold) that are used less than once per week. Purging should be approx. 1-3 minutes or until temperature stabilizes. The document goes on to state that these flushing's should happen weekly. A further review found that an example given under High Risk Conditions, states anywhere is the building where Stagnant water is present . and where Biofilm is present - sediment, sludge, scale, organic materials, and iron oxide . The document goes on to state, under the sub paragraph entitle Control Measures, that Conditions throughout the building water system are not always uniform. For this reason, control measures should be monitored in multiple locations throughout the building. Under monthly frequency it states Disinfection levels - Residual chlorine should be checked to ensure proper disinfection is available from municipal source. No Centers for Disease Control (CDC) Legionella tool-kit was observed completed as part of the facilities WMP.