STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira Nursing and Rehab	3200 State St Saginaw, MI 48602

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Numbers MI00142793 & MI00143087. Based on the interview and record review, the facility failed to honor the resident's wishes and identify the designated patient advocate, despite legal documentation brought in by the family, upon admission to clearly establish the resident's wishes of Do Not Resuscitate (DNR) for one resident (Resident #801) of three sampled residents reviewed for residents' rights and honoring the resident's and designated patient advocate's wishes for Do Not Resuscitate (DNR) resulting in Resident #801 receiving Cardiopulmonary Resuscitation (CPR) for approximately over an hour and later dying as witnessed by Resident #801's Designated Patient Advocates who were present to witness Resident #801 receiving CPR until Resident #801 was pronounced dead by the Emergency Medical Team (EMT) Ambulance who responded to the 911 call. Findings include: Resident #801 (R801): Resident R801 was admitted on [DATE] with the diagnosis of Encephalopathy, Essential (Primary) Hypertension, Type 2 Diabetes Mellitus with Diabetic Mononeuropathy and History of Transient Ischemic Attack (TIA), Cerebral Infarction, and Cerebral Edema in addition to other diagnoses. According to record review and interview with Social Services Director A (SS A) on [DATE] at 4:20 PM, R801 was assessed upon admission on [DATE], with a BIMS (Brief Interview for Mental Status) score of zero. SS A further explained that a BIMS score of zero to seven means that the person cognition was severely impaired. On [DATE] at 1:38 PM, A review of the Designation of Patient Advocate Form (DPOA) was reviewed. The document clearly stated that R801 appointed her husband as the primary Patient Advocate and her daughter as the appointed Successor Patient Advocate. The Designated Patient Advocate form was signed by R801 dated on [DATE]. The signed DPOA Form was witnessed and signed by two individuals on [DATE] attesting: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I declare that the person who signed this Designation of Patient Advocate signed it in my presence and is known to me. I also declare that the person who signed appears to be of sound mind and under no duress, fraud, or undue influence and is not my husband or wife, partner, child, grandchild, brother, or sister. I declare that I am not the presumptive heir of the person who signed the previous page, the known beneficiary of his/her will at the time of witnessing, his/her physician, or a person named as the Patient Advocate . The two legal witness signatures were both dated [DATE]. The Designation of Patient Advocate Form and Decision for Health Care/ Durable Power of Attorney for Health Care for R801 noted, This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity . The appointed Patient Advocate's name specified (R801's husband), and the Appointment of Successor Patient Advocate specified (R801's daughter) . .If I am unable to participate in making decisions for my care and there is no Patient Advocate or Successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and this document be treated as conclusive evidence of my wishes . This document is signed in the State of Michigan. It is my intent that the laws of the state of Michigan govern all questions concerning validity, the interpretation of its provisions, and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be . Noted, signed by R801 on [DATE]. According to R801's daughter, during a phone interview on [DATE] at 11:30 AM, she stated that R801's Designation of Patient Advocate for Health Care papers dated [DATE] was submitted to the facility upon admission to establish the Designated Patient's Advocate for R801 decision-maker for her care. The form was brought in and presented during the first and only Care Conference meeting with the facility. In the Designation of Patient Advocate for Health Care document, the DPOA 1 was identified as the husband, and successor DPOA 2 was R801's daughter, who was chosen to be the successor in case DPOA 1 was incapacity to exercise his duties as DPOA. The DPOA 2 was present during the care conference meeting on [DATE] and has acknowledged and signed the Baseline Care Plan dated [DATE] during the entire stay of their mother (R801). R801's daughter reported that there was no mention nor communication made to the family members that the DNR was invalid and that R801's wishes for DNR would not be honored. On [DATE] at 1:37 PM, a review of R801's Electronic Medical Records (EMR) showed evidence that there were several meetings with the husband DPOA1 (Designated Patient Advocate #1) and daughter DPOA 2 (Appointed Successor Patient Advocate) held upon admission on [DATE] and during the care conference meeting held on [DATE] to discussed the plan of care. The DPOA1 had signed the facility document entitled: DO-NOT-RESUSCITATE-ORDER .Upon review of this form, the following were noted: Signature 1: B. Patient Advocate Consent I authorize that in the event the declarant's (R801) heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility of its execution. This order will remain in effect until it is revoked as provided by law. Signed with printed name by the Designated Patient Advocate. (no date) (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Signature 2: A second signature was noted on the form under the physician's signature. (no date) The Director of Nursing (DON), on [DATE] at 2:30 PM, identified and validated that the signature belonged to the Medical Director/Physician of the facility. The DON validated that they failed to complete the form appropriately because it was not determined when the husband signed the DNR, and when the physician signed the order. She did not have a definitive answer when queried why the DPOA and the Medical Director's signatures were undated. She further explained that the DNR was signed by the DPOA prior to the two physicians signature deemed R801 incapacitated. The DON stated: It did not matter if the BIMS score is zero. The DNR order was voided because R801 the Incapacity to Make Health Care Decisions Form was not completed therefore, R801 status remained a Full Code. Signature 3: The third signature was noted below the physician's signature. It says: ATTESTATION OF WITNESSES The individual who has executed this order appears to be of sound mind and under no duress, fraud, or undue influence. Upon executing this order, the declarant has (has not) received an identification bracelet. Signed by the witness with printed name dated [DATE] was noted. The Director of Nursing (DON), on [DATE] at 2:30 PM, identified and validated that the witness signature in the form belonged to a nurse currently an employee in the facility. The DON further revealed that because the form was missing the dates, it was deemed invalid by corporate. Therefore, the R801 code status remained as a Full Code. When queried, the DON stated, It was our fault because we did not fill out the forms correctly. The Administrator was interviewed on [DATE] at 2:30 PM. The Administrator had indicated that she was not the administrator when the event occurred. The Administrator hire date at the facility was [DATE]st, 2024. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:20 PM, the Director of Social Services (SS A) was interviewed. SS A revealed that R801 was admitted on [DATE] with a BIMS score of zero assessment. He further explained that a score of zero means the Resident's cognition is severely impaired and she may not understand or make her own healthcare-related decisions. SS A indicated that the facility was in the process of obtaining signatures from two physicians for R801's Incapacity form completed to deem R801 incapacitated so that the DPOA papers would take effect. Without the incapacity form, R801 remains her own responsible person, but since R801 could not understand or could not sign the DNR, she remained a Full Code. The Medical Director (Physician1) signed the incapacity document dated [DATE], but it took a while for the Psychiatrist (Physician 2) to sign the form. The Incapacity to Make Health Decision form was finally completed on [DATE]. The SS A agreed and stated, It took a while. The SS A did not explain further why it took a while to obtain the signatures. When queried about the expected turnaround time for the two physician's signatures and the incapacity form to be completed, SS A did not answer. SS A confirmed that he did the BIMS Assessment upon R801's admission on [DATE], and R801's BIMS score was ,d+[DATE]. He further explained that a BIMS score of zero to seven indicates that the person has severe cognitive impairment. However, SS A indicated that he does not have the liberty to deem her incompetent. SS A revealed that they did not honor the DPOA document submitted by the family because the Incapacity form by two physicians' signatures was not completed. The DPOA document submitted by the family did not take effect because they are waiting for two physicians' signatures to determine the resident's incapacity to make health decisions. However, it was not completed until one month later, on [DATE]. R801's code status remained Full Code and was not changed in a timely manner. Because of this delay, R801 remained a Full Code,. R801's DNR Order signed by the Designated Patient Advocate therefore was not honored. A review of Nursing Progress Notes dated [DATE], at 18:39 (639 PM) revealed: The resident was found unconscious in the room around 5:40 PM. We called 911 and immediately we started CPR, we gave seven rounds of CPR, when the ambulance people arrived at 5:47 PM and took over. They started giving CPR for hours and then declared the resident dead at 6:34 PM. The family, physician and DON was notified about the resident condition. On [DATE] at 2:50 PM, the facility policy entitled Determination of an Advocate's Authority to Act on Behalf of a Resident with a facility implementation date of ,d+[DATE] reviewed by the facility yearly on ,d+[DATE], , d+[DATE], and ,d+[DATE] was reviewed. The purpose of the policy stated, This policy and procedure outline the process for determining who has health care decision-making authority for a resident, and when it is appropriate for a patient advocate/surrogate to act on behalf to act on behalf of a resident who lacks the competency and or capacity to actively participate in their health care treatment . The verbiage that the Incapacity to Make Health Care Decisions Form signed by the two physicians was not indicated in this policy entitled: Determination of an Advocate's Authority to Act on Behalf of the Resident. In fact, the facility's policy's Procedure, Interpretation, and Implementation stated that: 1. Upon admission, the building shall first determine if the resident's health care decision-making authority has been delegated to a court-appointed guardian, or resident has an activated Power of Attorney for health care in place. If so, the building shall note in the resident file who is authorized to make health care decisions for the resident . 6. In most, but not all cases, the resident's family member(s) shall be the patient advocate. The facility treats the person closest to the resident (e.g. living spouse, child) who participated in the admission as the patient advocate unless those participating in the resident's life mutually agree who shall be designated as the patient's advocate . (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Residents Rights Policy (,d+[DATE] version) was reviewed on [DATE] at 2:25 PM. The Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. The Policy Interpretation and Implementation specified: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a.) a dignified existence; b.) be treated with respect, kindness and dignity .h.) be supported by the facility in exercising his or her rights . k.) appoint a legal representative of his or her choice, in accordance to state law . The facility policy for Incapacity to Make Health Care Decisions was requested on [DATE] at 2:30 PM but was not received on the date and time of exit.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Number MI00145334 Based on interviews and record review, the facility failed to follow the facility policy to immediately report, conduct an investigation, and inform the local authorities, per facility policy, for one missing resident (Resident #802) of one sampled resident, whose whereabouts were unknown over 24 hours, resulting in the potential for harm from not receiving scheduled medications. Findings include: Resident #802 (R802): On 7/8/24 at 10:30 AM, a review of EMR records revealed R802 was admitted to the facility on [DATE] with a diagnosis of osteomyelitis of the left ankle and left foot requiring Intravenous (IV) antibiotic therapy. Other diagnosis listed were Diabetes Mellitus, Diabetic Neuropathy, Immunodeficiency Virus (HIV) Disease, Essential Hypertension, and Major Depressive Disorder in addition to other diagnoses. R802's discharge plan was to complete treatment regimen of IV antibiotics through the Intravenous (IV) Percutaneous Indwelling Central Catheter (PICC) Line on the left arm and discharge to the community once the treatment was completed. According to the Administrator, during an interview on 7/8/24 at 4:10 PM, R802 often left the facility during the day and returned at night. On 6/25/24, R802 left the facility but failed to return after midnight. The Administrator and the Director of Nursing (DON) were unaware, and no one had notified them that R802 did not return and was still missing after the morning stand-up meeting at 9:00 AM on 6/26/24. The facility attempted to call all his contact numbers over the phone. The Administrator had indicated that they had driven to his last address listed and talked to his brother-in-law, who did not know R802's whereabouts. The Administrator denied receiving notification from staff about a resident missing until after stand-up meeting. The Administrator denied reporting the incident to the state and said that the staff did not call the local authorities (police) when R802 was missing. When queried, the administrator said that they did not consider R802 an elopement and that it was not reportable because R802 was his own responsible party, and he could come and go on LOA (Leave of Absence) status. We did not consider it an elopement, and it was not reportable because R802 was alert and oriented and could go out of the facility. He is his own person and usually goes out on LOA. On mi night of 6/25/24, R802 did not return, and the following day, on 6/26/24, we searched for him inside the building and drove into town to look for him. We did not know where he was and his whereabouts. We drove around searching for him because he had medications that were due through his PICC line. When queried, why did she not report to the local authorities since she did not know his whereabouts? The Administrator did not have an explanation. When asked about the sign-out policy, the administrator revealed that R802 did not sign out at the front desk the day he left on 6/25/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator denied R802 signing (Against Medical Advice) AMA Form. R802 left at approximately 2:30 PM on 6/25/24 and did not return. While searching for R802 on 6/26/24, R802 was not found. The Administrator stated, It wasn't until around 5:30 PM on 2/26/24, that we stopped searching because I received a call from R802 apologizing for not returning before midnight. The administrator revealed that R802 told the Administrator that he had taken a lot of medications and fell asleep and forgot to call sooner. R802 did not return to the facility after the call. When queried about what medications? Or did R802 have medications given by the nurses while on LOA? The Administrator did not answer. The administrator had indicated that in cases like this, the staff should have followed the Missing Person Policy to activate the search and call the Administrator and local authorities while the search continued. The Administrator revealed she was not notified until the morning of the following day. The Administrator denied calling the local authorities to report a missing resident, and no report was sent to the state agency. An interview with the Director of Nursing (DON) was conducted on 7/8/24 at 2:45 PM. The DON stated that R802 left and that the staff member had not notify her that he had not returned at midnight. The DON indicated that she, and the Administrator, had driven through town to find the resident, but R802 was not found. The nursing staff on the midnight shift 6/25/24-6/26/24 (6 PM-6 AM) did not call to notify the Administrator that R802 was missing. The DON was asked if they reported the missing resident to the local authorities or the State Agency. The DON revealed that they did not call because R802 went on Leave of Absence (LOA) and signed out himself that day; therefore, elopement was not considered. When asked if she knew his whereabouts and his health and safety status while searching for him on 6/26/24? The DON stated, no. The DON revealed that the goal of R802's stay at the facility was to receive IV antibiotics through his PICC Line for his infected foot and ankle. R802 also had diabetes. The DON was asked if they found R802's during their search. She answered no. The DON was queried if she was worried about R802's health and safety, especially a venous line. The DON agreed that R802 was at high risk of staying out without the medication given as ordered and the potential hazard for PICC Line as a direct venous access. The Leave of Absence (LOA) Record and Signing Residents Out Policy was reviewed on 7/9/24 at 3:00 PM. It was verified by the receptionist on 7/9/24 at 9:25 AM, that R802 did not sign out on the day he left on 6/25/24. There was no record of him officially leaving the facility on 6/25/24 at a specific time. Nurse D was interviewed on 7/9/25 at 10:45 AM. Nurse D revealed that he was the nurse during the day, 6 AM- 6 PM shift on 6/25/24, when R802 left the facility and did not return before his shift ended. Nurse D recalled that R802's insulin was held at noon because his blood sugar was 66. Nurse D was unable to follow-up regarding his blood sugar because R802 had left during Nurse D lunch break. Nurse D indicated that R802 had an IV Medication scheduled at noon and administered Vancomycin at 9:17 AM, and Ceftriaxone at 12:26 PM. Both via PICC Line. Nurse D recalled and stated that: the antibiotic infusion takes about two hours to complete before it can be disconnected. R802 must have left at around 2:30 PM. The nurse manager must have disconnected him during my break and told me that R802 left LOA when I returned. R802 did not return from LOA during the shift change at 6:00 PM and passed it to the next shift during the report. Nurse D denied releasing R802 with medication to go with him when R802 left. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor requested the investigation file of R802 leaving the facility on 6/25/24. There was no facility investigation presented for review. Upon request, Administrator did not provide an investigation to determine whether the case was reportable or not. The investigation (time specific) timeline (#10 of the facility's: Missing resident event policy) was not provided to the surveyor at the date and time of exit. On 7/9/24 at 3:55 PM, the Signing Residents Out Policy (Reviewed by the facility on 5/24)was reviewed. Policy Statement: All residents leaving the premises must be signed out. Policy Interpretation and Implementation: 1. Each resident leaving the premises (excluding transfers/discharges) must sign out. If the resident does not sign out before LOA, the resident will be re-educated upon return . . 3. Unless otherwise prohibited by law, medications that must be administered while the resident is out will be given to the resident/person signing the resident out . On 7/9/24 at 4:00 PM, The facility policy was reviewed: Elopement Policy: Missing resident event (Reviewed and revised date:5/24) The facility's policy specifies under the section: Missing resident event The facility will implement the plan for conducting internal and external searches to locate missing residents. If the resident is discovered missing or suspected of having eloped, the charge nurse takes the following steps: 1. The charge nurse will initiate a search of the unit upon which the resident resides, with all employees assigned to the unit. 2. The charge nurse will notify the Administrator/DON nursing supervisor if the resident cannot be located on the assigned unit . . 9. If the resident cannot be located, the facility shall: a. Notify the Administrator/DON b. Notify the resident's family/responsible party c. Notify the police 10. Maintain a time specific timeline and actions taken. The facility's policy specifies under the section: Reporting Employees shall notify: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator or DON who will notify the State agency, as necessary by state requirement Family/Responsible Party On 7/9/24 at 4:20 PM, the Administrator denied getting a call from staff regarding a missing resident after midnight from the charge nurse that one of the residents did not return on 6/25/24. The Administrator and DON did not know R802's whereabouts and did not find him during their attempt to search on 6/26/24. The police were not called about the missing R802 per facility policy. The Unusual Event Investigation regarding R802 on 6/25/24-6/26/24, was requested for review, but the Administrator did not submit an investigation at the time of exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Numbers MI00142793, MI00143087, MI00143556, and MI00145334. Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for two residents (Resident #801 and Resident #802) reviewed for care planning by 1) Failing to address Resident #801's Advanced Directive and 2) Failing to address Resident #R802's frequent Leaves of Absence out of the facility, resulting in lacking a care plan with resident-specific interventions, staff actions, resident's/advocate's preferences of advanced directives (R801) and leave of absence status (R802) and a lack of clarity and directions specific to staff actions and interventions to deliver patient-centered care. Findings include: Resident #801 (R801): Resident R801 was admitted on [DATE] with the diagnosis of Encephalopathy, Essential (Primary) Hypertension, Type 2 Diabetes Mellitus with Diabetic Mononeuropathy and History of Transient Ischemic Attack (TIA), Cerebral Infarction, and Cerebral Edema in addition to other diagnoses. According to record review and interview with Social Services Director A (SS A) on [DATE] at 4:20 PM, R801 was assessed upon admission on [DATE], with a BIMS (Brief Interview for Mental Status) score of zero upon admission on 1//, d+[DATE]. SS A further explained that a BIMS score of zero to seven means severe cognitive impairment. The Director of Nursing (DON) was interviewed on [DATE] at 2:30 PM. The DON validated that the facility failed to complete the DO-NOT-RESCUCITATE DNR form appropriately, and the incapacity determination for R801 was not completed and signed timely by two physicians, the DPOA was not activated, and therefore, the DNR order was voided. The DON continued explaining that R801 code status remained a Full Code. The DON stated, It was our fault because we did not fill out the forms correctly. When two physicians finally signed the incapacity form on February 28, 2024, we still waited for the family to sign the DNR order form, but R801 died on [DATE]st before the family DPOA had a chance to sign and change R801's Full Code to DNR status. R801 received Cardiopulmonary Resuscitation from the facility staff and the Emergency Medical Services (EMS) Ambulance and was pronounced dead on [DATE]st at 6:34 PM. On [DATE] at 12:00 PM, the DON confirmed no care plan was created for R801's Advanced Directive section as she provided the surveyor with a copy of R801's care plan record. When asked why there was no care plan for the Advanced Directive, the DON did not have an explanation and left the room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:20 PM, the Director of Social Services (SS A) was interviewed. SS A revealed that R801 was admitted on [DATE] with a BIMS score of zero assessment. SS A further explained that a score of zero means the Resident's cognition is severely impaired, and she may not understand or make her own healthcare-related decisions. SS A indicated that the facility was obtaining signatures from two physicians for R801's Incapacity form completed to deem R801 incapacitated so that the DPOA papers would take effect. Without the incapacity form, R801 remains her own responsible person, but since R801 could not understand or could not sign the DNR, she remained a Full Code. The request of R801'sDesignated Patient Advocate for DNR was not honored. R801 received CPR on [DATE]st, 2024. On [DATE] at 4:00 PM, upon review of R801's Care plan, the Advanced Directive was not addressed. Resident #802 (R802): On [DATE] at 10:30 AM, a review of EMR records revealed R802 was admitted to the facility on [DATE] with a diagnosis of osteomyelitis of the left ankle and left foot requiring Intravenous (IV)antibiotic therapy, Diabetes Mellitus, Diabetic Neuropathy, Immunodeficiency Virus (HIV) Disease, Essential Hypertension, and Major Depressive Disorder in addition to other diagnoses. R802's discharge plan was to receive treatment of IV antibiotics through the Intravenous (IV) Percutaneous Indwelling Central Catheter (PICC) Line on the left arm and discharge to the community once the treatment was completed. R802 Pre-Admission Screening/Annual Resident Review (PASARR) Level I Screening dated [DATE] revealed that R802 has: 1.) a current diagnosis of Mental Illness, 2.) has received treatment of Elavil 50 mg BID (twice a day) and 3.) has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days received. According to the Administrator, during an interview on [DATE] at 4:10 PM, R802 often left the facility during the day and returned at night. On [DATE], R802 left the facility but failed to return after midnight. When queried, the Administrator had indicated that they did not consider R802 an elopement and that it was not reportable because R802 was his own responsible party. R802, according to the administrator, could come and go on LOA (Leave of absence) status. However, on the night of [DATE], T R802 did not return, and the following day, on [DATE], we searched for him inside the building and drove into town to look for him. We did not know where he was and his whereabouts. The Administrator also revealed that R801 did not sign out at the front desk the day he left, and R802 did not follow the LOA Policy. The Administrator agreed that R802 did not sign the AMA papers (Against Medical Advice), nor did he sign out of the facility for the Leave of Absence Record. The Administrator stated, R802 left the facility at approximately 2:30 PM on [DATE] and did not return. According to an interview with the Director of Nursing (DON) conducted on [DATE] at 2:30 PM. The DON stated that R802 left on [DATE] and did not return. The DON was asked if they reported the R802 missing to the local authorities or the State Agency. The DON revealed that they did not call the local police and state because R802 went on Leave of Absence (LOA) and signed out himself that day; therefore, elopement was out of the question. The DON was queried regarding the frequent LOA Care Plan and the plan in place when R802 did not return. The DON did not have a reply. On [DATE] at 4:05 PM, a Record Review was conducted. R802's care plan did not address his behavior or pattern behavior of leaving the building frequently (frequent LOA), and the facility's interventions, tasks, and actions were to monitor and maintain R802's safety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Care Plan Policy and other policies on [DATE] at 12:00 PM were requested from the DON for review. The facility's Advanced Directives/Advance Care Planning policy was reviewed on [DATE] at 2:32 PM. The policy statement: Advanced Directive will be respected in accordance with state law and facility policy . .9. The attending Physician will provide information to the resident and legal representative regarding the resident's health status, treatment options, and expected outcomes during the development of the initial comprehensive assessment and care plan. 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and or advanced directive . The facility did not provide the Care Planning Policy during exit.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Number MI00143087. Based on interview and record review, the facility failed to follow the wishes of one resident (Resident #801) pertaining to Do Not Resuscitate (DNR) of 5 residents reviewed for Code Status, resulting in Resident #801 receiving a Full Code status not honoring the resident/patient advocate's wishes due to delay caused by the facility and potential for injury, pain and suffering for the resident to experience Cardiopulmonary Resuscitation (CPR) and the resident's family DPOA to witness CPR given to Resident #801 against their wishes. Findings include: Resident #801 (R801): On [DATE] at 12:15 PM, a review of the Nursing Clinical Progress notes dated [DATE] at 18:39 revealed that resident (R801) was found by Nurse C unconscious in her room around 5:40 PM on [DATE]. Staff called 911, and immediately started Cardiopulmonary Resuscitation (CPR). Staff reported giving seven (7) rounds of CPR until the ambulance people arrived at 5:47 PM and took over and continued giving CPR. The nurse wrote: They started CPR for hours and at 6:34 PM, The EMS Ambulance staff declared the resident dead. Nurse C during the interview described that the family arrived and saw staff in full action and giving R801 CPR. Nurse C recalled that there was a lady, R801's husband who was the DPOA, and another man. The lady started yelling, re: no notification; and was asking, what happened to her (R801). Like, blaming the staff. R801's husband according to Nurse C said: Nobody notified us . On [DATE] at 12:00 PM, a review of R801's Electronic Medical Record (EMR) revealed that Resident R801 was admitted on [DATE] with the diagnosis of Encephalopathy, Essential (Primary) Hypertension, Type 2 Diabetes Mellitus with Diabetic Mononeuropathy and History of Transient Ischemic Attack (TIA), Cerebral Infarction, and Cerebral Edema in addition to other diagnoses. According to the record review conducted on [DATE] at 4:15 PM, the Admission assessment dated [DATE], and interview with Social Services Director A (SS A) on [DATE] at 4:20 PM, confirmed that R801 was assessed upon admission on [DATE], with a BIMS (Brief Interview for Mental Status) score of zero upon admission. SS A further explained that a BIMS score of zero to seven means the person has severe cognitive impairment. On [DATE] at 12:00 PM, the DON confirmed no care plan was created for R801's Advanced Directive section as she provided the surveyor with a copy of R801's care plan record. When asked why there was no care plan specific for the R801's Advanced Directive, the DON did not have an explanation and left the room. The Facility's Policy for Care Planning was then requested. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the family Interview on [DATE] at 12:05 PM conducted via phone, R801's daughter had expressed concern about R801's Designation of Patient Advocate for Health Care Form dated [DATE] was submitted to the facility upon admission to establish the Designated Patient's Advocate for R801 decision-maker for her care. The form was brought in and presented during the first and only Care Conference meeting with the facility. In the Designation of Patient Advocate for Health Care document, the DPOA 1 was identified as R801's husband, and successor DPOA 2 was R801's daughter, who was chosen to be the successor for DPOA 1. The DPOA 2 was present during the meeting on [DATE] and has acknowledged and signed the Baseline Care Plan dated [DATE] during the entire stay of their mother (R801). R801's daughter reported that there was no mention nor communication to the family members that the DNR was invalid and that R801's wishes for DNR would not be honored. A review of submitted POA documents dated [DATE] reviewed on [DATE] at 1:38 PM, specified: Title of Document: Designation of Patient Advocate Form (DPOA) The document clearly stated that R801 appointed her husband as the Patient Advocate and her daughter as the appointed Successor Patient Advocate. The Designated Patient Advocate form was signed by R801 on [DATE] and was witnessed and signed by two individuals on [DATE], who attested as witnesses to R801's POA designation. It says: I declare that the person who signed this Designation of Patient Advocate signed it in my presence and is known to me. I also declare that the person who signed appears to be of sound mind, under no duress, fraud, or undue influence, and is not my husband or wife, partner, child, grandchild, brother, or sister. I declare that I am not the presumptive heir of the person who signed the previous page, the known beneficiary of his/her will at the time of witnessing, his/her physician, or a person named as the Patient Advocate . The two legal witness signatures were both dated [DATE]. The Designation of Patient Advocate Form and Decision for Health Care/ Durable Power of Attorney for Health Care for R801 noted, This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity . The appointed Patient Advocate's name specified (R801's husband), and the Appointment of Successor Patient Advocate specified (R801's daughter) . .If I am unable to participate in making decisions for my care and there is no Patient Advocate or Successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and this document be treated as conclusive evidence of my wishes . This document is signed in the State of Michigan. It is my intent that the laws of the state of Michigan govern all questions concerning validity, the interpretation of its provisions, and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be . Noted, signed by R801 on [DATE]. On [DATE] at 1:37 PM, a review of R801's Electronic Medical Records (EMR) showed evidence that there were meetings held with the husband DPOA1 (Designated Patient Advocate #1) and daughter DPOA 2 (Appointed Successor Patient Advocate) upon admission on [DATE] and especially during the Care Conference meeting held on [DATE] to discussed R801's plan of care. The DPOA 1 had signed the facility document entitled: DO-NOT-RESUSCITATE-ORDER . (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R801's DO-NOT-RESUSCITATE form was reviewed on [DATE] at 4:15 PM. It revealed that: The form was witnessed on [DATE], and three (3) signatures were noted: 1.) Designated POA R801's husband, 2.) R801 Primary Physician/Facility Medical Director, 3.) Facility staff (as witness). The Director of Nursing (DON), on [DATE] at 2:30 PM, identified and validated that the witness signature in the form belonged to a nurse currently an employee in the facility. The DON further revealed that because the form was missing the dates, it was deemed invalid by corporate. The DON stated, It doesn't matter BIMS - Not without being deemed by two (2) physicians. Without the two doctor signatures, status remained a Full Code. When queried, the DON stated, It was our fault because we did not fill out the forms correctly. And it took a while for the incapacity form to be signed. It was finally completed on [DATE]. The code status was not changed as quickly, R801 died on [DATE]st (2 days later) at 6:34 PM. On [DATE] at 12:00 PM, the DON confirmed no care plan was created for R801's Advanced Directive section as she provided the surveyor with a copy of R801's care plan record. When asked why there was no care plan for the Advanced Directive, the DON did not have an explanation and left the room. SW Progress notes revealed Late Entry created on [DATE] at 13:15 (1:15 PM) 3 days after R801 had expired, for the date [DATE] at 15:15 (3:15 PM): Late Entry #1 Note Text: Spoke with husband, reviewed resident deemed incapacitated and activation of POA. Discussed filling out DNR paperwork per wishes . Late Entry #2 Note Text: Daughter to bring in husband/POA on Monday to fill out DNR paperwork. SS A, during an interview on [DATE] at 4:20 PM, had indicated that the facility was in the process of obtaining signatures from two physicians for R801's Incapacity Form to be completed to deem R801 incapacitated so that the DPOA papers would take effect. He clearly stated that the law says Without the incapacity form, R801 remains her own responsible person. SS A indicated that since R801 could not comprehend or sign the DNR, she remained a Full Code . The Medical Director (Physician 1) signed the incapacity document dated [DATE], but it took a while for the Psychiatrist (Physician 2) to sign the form. The Incapacity to Make Health Decision form was finally completed on [DATE]. On [DATE] at 4:30 PM, the Incapacity Form for R801 was reviewed, and the completion date was noted as [DATE]. The Primary Physician signed the form on [DATE], and the Psychiatrist signed it on [DATE]. The facility took 29 days to obtain signatures from the two physicians. On [DATE] at 4:20 PM, the SS A was asked about the expected turnaround time for the two physician's signatures and the incapacity form to be completed. The SS A agreed and stated, It took a while. The SS A did not explain why obtaining the signatures took a while (from [DATE] to [DATE]). SS A confirmed, however, that SS A performed R801's BIMS Assessment upon admission on [DATE], and R801 was deemed to have severe cognitive impairment with a score of zero (,d+[DATE]). (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:30 PM, a review of progress notes dated [DATE], at 18:39 (6:39 PM) revealed: Resident was alert to name during the day; she was not energetic as it was the last time I saw her February 24, 2024, but she was able to take her medications well. According to the night shift nurse report, the resident (R801) was declining, and her eating appetite was decreasing. When I saw the resident this morning to give her medication, she took it well and drank 120 ml of Med Pass (protein supplement) .The last time I checked the resident (R801) was around 4:48 PM. I checked her blood sugar, it was 294 mg/dL. 6 units of Humalog was given . The Resident was stable when I left the room . Around 5:40 PM, one of the CNA's notified that the resident had problems breathing. I went to assess the resident immediately. The resident became unresponsive. I asked the help of other nurses. CPR was immediately started, and AED Pads were placed. No shock is necessary. We started giving CPR with another nurses until the ambulance people arrived and took over . MMR (Emergency Medical Response Ambulance) continued to perform CPR until 1834 and was pronounced deceased by MMR staff. According to Nurse C during an interview conducted on [DATE] at 1:05 PM, Nurse C recalled that at around 5:40 PM on [DATE]st, 2024, a CNA came and asked me to check on R801. CNA came to her room to deliver R801's dinner tray when they noticed and called for her (Nurse C). R801 was not responding, and R801 stopped breathing. We did not call Code Blue but asked other nurses to help, and other nurses came to help. Staff gave compressions until the ambulance staff came and then called the family. Nurse C called the family to inform them that R801 was unconscious and called the ambulance to send her to the hospital. And the family's reply was, We will be there. When I called the ambulance the first time, R801 was still breathing. When I returned to assess R801, the resident was no longer breathing. The family stated later to me that no one had informed or called them about her declining condition. Nurse C was confident and stated, When I assessed R801 and found that her vitals were abnormal, I made sure of her code status. We assessed and used the BP machine to check her blood pressure, which was low; oxygen saturation was low, and the pulse on the wrist was very fast (radial artery) until no breathing was observed. Nurse C said, I looked at her medical record on the computer to confirm that she was a FULL CODE. We started CPR, took turns, and applied AED on her. The AED prompted but did not recommend delivering shocks, so we continued CPR. In less than fifteen (15) minutes, the ambulance came and took over. The ambulance used a machine and continued CPR before R801 was pronounced. The family was called, and they came. They saw staff perform CPR. It was a lady, R801's husband, and another man. The lady started yelling, re: no notification; what happened to her? Blaming all of us. Husband said: Nobody notified us . However, after R801 was deceased , the EMS Ambulance staff talked to them as they were furious. R801's family calmed down after a while. Nurse C indicated that she had documented her nurse's notes in PCC. The DON, the Doctor, and the family were all notified. It was at the end of the shift at 6:34 PM when she passed, so Nurse C explained that she did not see or check her chest for bruising or any other abnormalities. After R801 was pronounced deceased by the EMS staff, the incoming nurse (6 PM to 6 AM) took over, and I went home. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Nurse B during an interview on [DATE], at 9:55 AM, Nurse B worked that day in another unit and assisted Nurse C. Nurse C and her observed R801 having shallow breathing and had stopped breathing. They called the code, got the crash cart, and started CPR. The MMR (ambulance) was called, and they continued CPR until the ambulance arrived. Nurse D from the 100's unit also came and helped with CPR. When the ambulance arrived, they took over. Nurse B stated, Then, I left to return to my unit to do a shift change report around 6:00 PM. Nurse B indicated that they called the EMS Ambulance when R801 did not have vital signs (heart rate, breathing, Blood Pressure, and Oxygen saturation reading) after R801 stopped breathing. Staff applied the Automatic External Defibrillator (AED) and prompted us to continue CPR. On the Face sheet and Point Click Care (PCC), R801 was a Full Code. Nurse B stated, We verified it with Face Sheet - saw full code written that's why we started the CPR and applied AED when she stopped breathing and no vitals on [DATE]. Nurse D was interviewed on [DATE] at 10:30 AM. Nurse D recalled the event on [DATE]st, 2024. R801 was receiving CPR when Nurse D arrived at the scene. He remembered being a bit late because he did not hear the code overhead but was told to help. The nurses were doing CPR and took over to relieve them. Nurse D indicated that he did CPR on R801 for about approximately ten (10) minutes before the EMS Ambulance arrived at the scene and then recalled leaving to return to my unit to give the change of shift report. Nurse D indicated that he gave a good 30 minutes' worth of CPR. He also took over the other nurses, assuming they had checked the code status, and relieved the nurses because it was already happening. The Certified Nurse Aide (CNA E) was interviewed on [DATE] at 11:30 AM. CNA E revealed on the day R801 passed away, CNA E helped another CNA assigned to R801. CNA E observed and described R801 as looked like she was gone. They went and got Nurse C and also got Nurse B. Nurse C, said she was a Full Code and started CPR immediately. The staff called for a Code overhead to alert all nurses. Nurse D and another Nurse F came from other units. We saw R801's family arrive, and they made so much noise, described as yelling, screaming, and crying. CNA E stated, They just blew up and were very upset. They were shocked seeing their mother's condition and seeing her receiving CPR in front of them. CNA E further described that she left to go back to her unit then returned to helped the other CNA after R801 was deceased . CNA E described noticing R801's chest had a big bruise where they did compressions. CNA E recalled being asked by the family, what happened to (R801) chest? The family asked CNA E what's all that? (family pointing at R801's chest discoloration). CNA E did not answer the family. The Administrator was interviewed on [DATE] at 2:30 PM. The Administrator had indicated that she was not the administrator when the event occurred. The Administrator hire date at the facility was [DATE]st, 2024. On [DATE] at 2:50 PM, the facility policy entitled Determination of an Advocate's Authority to Act on Behalf of a Resident with a facility implementation date of ,d+[DATE] reviewed by the facility yearly on ,d+[DATE], , d+[DATE], and ,d+[DATE] was reviewed. The purpose of the policy stated, This policy and procedure outline the process for determining who has health care decision-making authority for a resident, and when it is appropriate for a patient advocate/surrogate to act on behalf to act on behalf of a resident who lacks the competency and or capacity to actively participate in their health care treatment . The Policy entitled: Determination of an Advocate's Authority to Act on Behalf of a Resident reviewed by the facility on ,d+[DATE] specified: (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure, Interpretation, and Implementation: 1. Upon admission, the building shall first determine if the resident's healthcare decision-making authority has been delegated to a court-appointed guardian, or resident has an activated Power of Attorney for healthcare in place. If so, the building shall note in the resident file who is authorized to make health care decisions for the resident . . 6. In most, but not all cases, the resident's family member(s) shall be the patient advocate. The facility treats the person closest to the resident (e.g., living spouse, child) who participated in the admission as the patient advocate unless those participating in the resident's life mutually agree who shall be designated as the patient's advocate . The facility's Residents Rights Policy (,d+[DATE] version) was reviewed on [DATE] at 2:25 PM. Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Procedure, Interpretation and Implementation specified: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity .h. be supported by the facility in exercising his or her rights .k. appoint a legal representative of their choice, in accordance to state law . The Facility Policy for Incapacity to Make Health Care Decisions was requested on [DATE] at 2:30 PM but was not received on the date and time of exit.