STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235250	A. Building B. Wing	10/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Numbers MI00147548 and MI00147625. Based on observation, interview and record review, the facility failed to ensure dignified, respectful, and professional care and treatment for 12 residents (# 5, #11, #21, #24, #29, #36, #39, #40, #60, #64, #76, and #81) of 12 residents reviewed and 12 of 12 residents from the confidential Resident Group meeting, resulting in a lack of the provision of care, timely response to care needs, extended wait times for assistance, incontinence, and residents' verbalizations of discourteous staff, feelings of being a burden, frustration, and sadness. Findings include: Resident #11: Record review revealed Resident #11 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included left leg fracture, diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD), depression, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required substantial to total assistance to complete all Activities of Daily Living (ADL) with the exception of eating. On 10/28/24 at 11:57 AM, Resident #11 was observed sitting in a wheelchair in their room. An interview was completed at this time. When queried regarding staffing levels at the facility, Resident #11 replied, Night shift is the worst. When asked what they meant, Resident #11 stated, It took over two hours last night for staff to answer their call light. Resident #11 revealed they have to call the facility on their phone to get help. Resident #11 was asked how frequently that occurs and indicated it is a nightly occurrence. Resident #11 then stated, If something was really wrong, I would be dead. When asked how that makes them feel, Resident #11 stated, Horrible, (staff) don't care. When asked if staff treat them with dignity and respect when they are in the room, Resident #11 verbalized they do not. Resident #11 was asked to provide an example. Resident #11 revealed they are able to eat independently but need assistance to prepare their food such as opening containers and cutting up items due to their tremors. Resident #11 then stated, (Staff) wont even prepare my meal for me anymore like I need. Just runs off without talking. When asked, Resident #11 reiterated the staff don't care and it makes them feel horrible. Resident #29: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/28/24 at 12:06 PM, Resident # 29 was observed in their room. The Resident was lying in bed, positioned on their back. An interview was completed at this time. Resident #29 was female and noted to have long, thick, dark colored hair on their chin. When queried regarding their stay at the facility, Resident #29 revealed they came to the facility approximately one month prior from the hospital. Resident #29 stated they had a stroke and needed therapy. When asked how therapy was going, Resident #29 indicated they were doing well in therapy and relayed do Not get therapy every day. When queried if they need staff assistance to get out of bed, Resident #29 stated, Not get therapy then no get out of bed. When asked why, Resident #29 did not provide a response. When asked how they transfer and get out of bed, Resident #29 replied, One or two staff have to help them. When queried regarding how they use the bathroom, Resident #29 stated, They (staff) put diapers on. Resident #29 was asked if they know when they need to use the bathroom and stated, Yeah but it takes them an hour to answer the call light. When asked if they put the call light on when they needed to use the restroom, Resident #29 nodded their head to indicate they did and reiterated that it takes over an hour for the staff to respond. With further inquiry, Resident #29 revealed facility staff tell them to go in their brief because they do not have time or staff to help them to the bathroom. Resident #29 indicated it is easier for the staff to change their brief than it is for them to assist them to use the toilet. A bedside commode was not observed in the Resident's room. When queried if staff had attempted to assist them to use a bedside commode, Resident #29 revealed staff had never offered/provided a bedside commode. When queried how it makes them feel to urinate and/or have a bowel movement in their brief, Resident #29 replied, Bad and verbalized it makes them feel like they are a baby. Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses which included right sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarction (stroke), osteoarthritis, depression, and falls. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required partial to total assistance to complete ADL. Review of Resident #29's Electronic Medical Record (EMR) revealed a care plan entitled, I have an ADL self-care performance deficit related to CVA (Cerebrovascular Accident - stroke) with right side weakness . (Initiated: 10/6/24; Revised: 10/15/24). The care plan included the interventions: - Toilet USE: I require assistance by (2) staff for toileting (Initiated: 10/6/24; Revised: 10/21/24) - Transfer: I require assistance by (2) staff to move between surfaces (Initiated: 10/22/24) A follow up interview was completed with Resident #29 and Family Member Witness FF on 10/31/24 at 11:11 AM in the Resident's room. Resident #29 was observed laying in bed on their back. When queried the average length of time it takes for staff to answer their call light, Resident #29 reiterated it is typically over an hour. Witness FF then stated, It $400.00 a day and they (staff) give me attitude when ask for help and say they don't have enough staff, but they can't wait for their money. When asked to explain, Witness FF revealed they have to go and find staff to assist Resident #29 when they are visiting because they do not answer their call light. When asked what they meant when they said attitude, Witness FF revealed the staff are rude and act as though you are bothering them when you need something. When queried if staff tell them to go to the bathroom room in their brief because they do not have time to help them, Resident #29 replied, Yes. Witness FF added, The perception in there is no urgency to assist the residents. Resident #29 was then queried regarding the visible hair on their chin and stated, No, don't want. They (chin hairs) bother me. When queried if staff had offered to assist them to remove the hair, Resident #29 revealed they had not. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 11:28 AM on 10/31/24, an interview was conducted with Registered Nurse (RN) CC. When queried if staff are expected to assist residents to remove unwanted facial hair, RN CC indicated they assume that would be included in daily ADL care. An observation of Resident #29 was completed with RN CC at this time. When queried regarding the Resident's facial hair, RN C stated they would get rid of the whiskers. No further explanation was provided. Resident #60: Record review revealed Resident #60 was admitted to the facility on [DATE] with diagnoses which included dementia, malnutrition, arthritis, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required substantial to total assistance to complete all ADL with the exception of eating. On 10/28/24 at 12:14 PM, Resident #60 was observed laying in bed in their room with their eyes open wearing a hospital style gown. The room lights were off, the blinds were closed, and there was no visual and/or audio sensory stimulation. A fall mat was noted on the floor on the left side of the Resident's bed. Resident #60's call light was not within reach. The call light cord was hanging over the head of the bed with the button on the floor under the headboard. When queried regarding the care they receive at the facility, Resident #60 replied, I got a sore spot on my butt it ain't going away. Resident #60 then stated, Been waiting to talk to nurse about my butt. When queried regarding staff responsiveness when they put on their call light, Resident #60 did not provide a direct response and indicated they just have to wait. Resident #60 was asked how they get assistance if they need it and revealed they did not know where their call light was. On 10/30/24 at 5:13 AM, Resident #60 was observed in their room from the hallway of the facility. The Resident was uncovered with their brief exposed and visible from the hallway. There were no staff present in the hallway or general area. Upon entering the room, Resident #60 was observed to be awake. The Resident's call light was not within the Resident's reach and was wrapped around the headboard of the bed. When queried how they were doing, Resident #60 indicated they were cold and asked for a blanket to cover up with. A blanket was not observed on the floor and/or area surrounding the Resident's bed. When asked what happened to their blanket, Resident #60 did not provide an answer. An interview was completed with RN CC on 10/30/24 at 8:29 AM. When queried regarding observation of Resident #60 being exposed and visible from the hallway and not having a blanket, RN CC responded that Resident #60 removes their blankets. When asked why there where no blankets in or around the bed if the Resident had removed it, RN CC was unable to provide an explanation. When queried regarding observations of the Resident's call light not being in reach, RN CC verbalized resident call lights should be positioned where they can reach them. No further explanation was provided. Resident #76: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/28/24 at 12:19 PM, Resident #76 was observed laying on their back in bed in their room. The Resident was wearing a visibly soiled blue long sleeve shirt with significant amounts of chunks of unknown substances on it. The Resident was unshaven and had an unkept appearance. Resident #76 was tall, and both of their feet were noted to be pressed against the footboard of the bed. The Resident did not have a bed extension in place. Resident #76's left upper arm was positioned by their side in bed. Their arm was discernibly edematous, and their hand was positioned in a fist. When queried, Resident #76 revealed they had a stroke which effected their left side. When queried if they were able to move their left arm and hand, Resident #76 indicated they could not. The Resident's fingernails were observed to be long and unkept with sharp edges and had a build up of dark colored unknown substances under the nail. When queried regarding the care they receive at the facility, Resident #76 stated, This place is terrible. When asked why, Resident #76 replied, The aides have attitude. Resident #76 was asked how the aides have attitude and replied, They tell me its not their job when ask for help. With further inquiry, Resident #76 stated, The one lady wouldn't give me a bed bath - she told me that wasn't her job. When asked if another staff member assisted them to wash up/gave them a bed bath, Resident #76 revealed they did not. Resident #76 revealed they returned to the facility from the hospital a few weeks prior and when they asked for something the aide (Certified Nursing Assistant [CNA]) told me, I don't give a damn about you. When asked if they had any other examples, Resident #76 stated, My urinal was half full on my (overbed) table and I ask them (staff) to empty it. (Staff) said I'm tired of emptying your piss. Resident #76 stated, They (staff) mistreating me. Resident #76 verbalized staff also do not respond to their call light timely. When asked how long it takes for staff to answer their call light on average, Resident #76 responded that it is usually an hour or two. Resident #76 then stated, There was a lady on the floor. I had my call light on for an hour and nobody came so I called my wife (on the phone). Resident #76 revealed their wife proceeded to call the facility and staff responded. When asked where the lady was at on the floor, Resident #76 indicated they were in the hallway by the doors to the unit. Resident #76 then stated, (Another Resident) lay on the floor all night yelling out. When asked if staff responded, Resident #76 revealed it was hours later and stated, (Staff) were cussing at (other resident) because they were hollering out when they did respond. Resident #76 then stated, You should come in between 1:00 AM and 6:00 AM to see what going on in here. When queried regarding ADL care including bathing, Resident #76 revealed the facility staff tell them they do not have enough staff to assist when they request bathing. When queried regarding their shirt, Resident #76 verbalized they have been wearing the same shirt for the past two days. Resident #76 stated, I asked them (staff) to change it and revealed facility staff had ignored their request. When asked how tall they are, Resident #76 replied, 6 (foot) 4 (inches). Resident #76 was queried regarding their feet being directly against the footboard and revealed their feet have always been against the footboard since they were admitted to the facility. Resident #76 further revealed there are night shifts when there is only one CNA working. When asked how they know there is only one CNA working, Resident #76 replied that staff tell them and explained that is why they cannot assist them. At the conclusion of the interview, Resident #76 stated, They (staff) will pick on me because I talk to you. Resident #76 was asked to explain and revealed staff do not like it when you tell the truth. Resident #76 indicated facility staff will try to discredit what them but verbalized they just wanted people to be treated right. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses which included left sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarct (stroke), heart failure, diabetes mellitus, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to total assistance to complete all ADL. On 10/31/24 at 12:03 PM, Resident #76 was observed laying in their bed from the hallway of the facility only wearing a shirt and a brief. The Resident was uncovered, and their brief was exposed and visible from the hallway of the facility. Upon entering the room, a blanket was not observed on the bed. When queried why they were uncovered and not wearing any pants, Resident #76 stated, Been waiting for (CNA C) to bring a blanket. When queried how long they had been waiting, Resident #76 revealed it had been around an hour. Resident #81: Record review revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, dementia, depression, heart disease, and left leg below the knee amputation. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required partial to total assistance to complete all ADL with the exception of eating. On 10/31/24 at 11:09 AM, Resident #81 was observed laying in bed, uncovered with their brief exposed from the hallway room entrance. There were no facility staff in the unit and/or general area of the Resident's room. An interview was completed with the facility Administrator on 10/31/24 at 10:46 AM. The DON was informed of statements made by residents during interviews as well as observations. The Administrator verified concerns and revealed the facility had work to do. 38471 During a confidential Resident Council meeting held on 10/29/2024 at 11:30 AM, the twelve residents in attendance were queried regarding the care provided to them at the facility. They reported the following concerns with their provisions of care: -Water pass is not consistently being completed and many times they will not receive waters on third shift. -Facility staff take 30-45 minutes to answer call light and upon them responding, they report they were doing something else. Call light response times are most extended on 1st and 3rd shift. -Members reported their families have entered the building and observed staff sitting at the nursing station playing on their phone or chatting with one another as call lights are alarming. -When aides answer their call lights they are snappy, abrupt and have poor attitudes. They further expressed they will ask what do you want, upon entering the room and it makes them feel as they are a burden. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At shift change there is no consideration that residents are sleeping, and staff are talking and laughing loudly. -Aides will come in their rooms and use their cellphones when they are supposed to be providing care. On 10/31/2024 at approximately 8:15 AM, a review was conducted of the last 6 months of resident council notes, and it revealed the following regarding resident complaints regarding call lights and hydration: October 1, 2024: .See concern form about residents not getting water on all sifts and when it does come its warm. See concern from about call light response times it depends on the staff and the shift who are slow to respond . September 3, 2024: See concern form about residents not getting water on all sifts and when it does come its warm. See concern from about call light response times it depends on the staff and the shift who are slow to respond . August 6, 2024: .The following residents (four residents) did express concern with call light response times, doors being slammed and people talking loud at night and early morning . July 2, 2024: . (two residents) do have concerns with doors being slammer and staff talking loud/high pitch giggling usually first thing in the morning and late at night . stated we don't always get fresh water, something its first shift that don't it out and other times its second shift that forgets to give us water . June 4, 2024: .stated we don't always get fresh water, something its first shift that don't it out and other times its second shift that forgets to give us water . 22927 Resident #5: In an interview on 10/28/24 at 10:40 AM with Resident #5 complained of being put to be at 7:00 PM and does not like it. The Resident #5 would like to stay up and do activities, and visitors come in the evenings. Resident #5 stated that there is a Certified Nurse Assistant (CNA) that comes into the room and just states 'what do you want, now' Resident stated that she tries not to use the call light because of the staff. Record review of the Resident #5' care plans medical record revealed the resident was a mechanical lift for transfers. Record review of Resident #5's Kardex care guide revealed that there was no bedtime identified for the resident. Resident #40: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/28/24 at 09:46 AM with Resident #40 revealed that she feels that the staff are not nice and don't do the work. Her catheter care does not get done and the staff are rude, and it take a long time to get call lights answered, but she can hear the staff in the hallway laughing and loud at night. Record review of Resident #40's care plans for activities of daily living (ADL) revealed that the resident required physical assist of two staff members with repositioning, toileting, mechanical transfers, dressing, and bathing/showers. In an interview on 10/28/24 at 03:40 PM with Resident #40 revealed that the Resident feels that there are not enough staff to help her as a quadriplegic mechanical lift person and that she has to wait long periods of time to get assistants. 49944 Resident #21 (R21): R21 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include difficulty walking, muscle weakness, major depressive disorder and obstructive uropathy. R21 has a BIMS (brief interview for mental status) score of 15, indicating they are cognitively intact. On 10/30/24 at 11:24 AM, R21 was observed sitting in their wheelchair, their head was down on the bedside table and they were sleeping. There was a large puddle of urine on the floor under the wheelchair, some of the puddle had started to dry and the room had a strong odor of urine that was noticeable from the hallway. This surveyor approached R21 and woke them up. R21 was asked how long she has been like this. R21 stated they have been like this since breakfast. R21 turned on their call light at 11:26 AM. R21 was asked if it takes a long time to get their call light answered and if being incontinent has ever happened before as a result of the long answer time. R21 stated it takes a long time to get the call light answered and this has happened before. Staff was observed responding to R21 at 11:48 AM. Staff told R21 they would be right back and left the room, staff entered the room again at 11:50 AM, staff then left the room again without providing care. Staff entered the room again at 11:53 AM to provide care. Resident #24 (R24): R24 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure, chronic obstructive pulmonary disease, anxiety disorder and hypertension. R24 has a BIMS score of 14, indicating they are cognitively intact. On 10/28/24 at 11:22 AM, an interview was conducted with R24. R24 was asked how the staff treats them. R24 stated the nurse aides have attitudes, and they give them a hard time about taking a shower. R24 stated that they use supplemental oxygen, and the nurse aides give them a hard time about refilling the portable oxygen tank. R24 was asked if they have any issues getting the call light answered timely. R24 stated, sometimes the call light can be on a couple of hours and it's on so long I will forget how long its been on. Resident #36 (R36): (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R36 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include adult failure to thrive, anxiety disorder, dysphagia and muscle weakness. R36 has a BIMS of 14, indicating they are cognitively intact. On 10/28/24 at 03:57 PM, an interview was conducted with R36. R36 was asked how the staff treats them. R36 stated some of the staff can be mean, one specific person (R36 doesn't know the name of this person), tells her that if she continues to turn her call light on she will just put her in her wheelchair and put her out by the nurses station. R36 stated they asked the aide their name, but the aide wouldn't tell R36 their name. R36 stated they are afraid to ask this aide for anything because of how mean they can be. Resident #39 (R39): R39 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include type two diabetes, difficulty in walking, dysphagia and urine retention. R39 has a BIMS score of 9, indicating they have mild cognitive impairment. R39 is alert and able to answer questions. On 10/28/24 at 02:10 PM, an interview was conducted with R39. R39 was asked how the staff treats her. R39 stated the staff are rude and they cuss while providing care, the cussing can be in general or directed at them. R39 stated they just want the staff to be nice. R39 was asked if it is any specific shift or staff member. R39 stated it is all shifts and no one specific. R39 is concerned that staff treat them badly, even though they feel they are obedient and does what the staff ask. Resident #64 (R64): R64 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following a cerebral infarction, muscle weakness, hypertension and muscle wasting. R64 has a BIMS score of 15, indicating they are cognitively intact. On 10/28/24 at 10:57 AM, an interview was conducted with R64. R64 was asked how the staff treats them. R64 stated that some of the staff is very nice, however, others make you feel like you are a problem to them. R64 was asked if it was any specific staff or shift. R64 stated that they though it was second or third shift staff that were the problem. R64 was asked if they get their call light answered in a timely fashion. R64 said it usually takes around 20 minutes or more to get assistance with the call light and it has been worse since their room change to the current room.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to respect the resident's choice to refuse a room change for one resident (Resident #64) of one resident reviewed for choices, resulting in feelings of sadness and hopelessness. Findings include: Resident #64 (R64): R64 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hypertension, hyperlipidemia, difficulty walking and hemiplegia and hemiparesis following cerebral infarction. R64 has a Brief Interview for Mental Status (BIMS) score of 15, indicating they are cognitively intact. On 10/28/24 at 10:51 AM, R64 was observed sitting in their wheelchair and watching television. This surveyor asked R64 how long they had been at the facility, R64 stated it had been about six months and they were moved to this room on June 17th. R64 was visibly upset and stated said they did not agree to a room change and they were unhappy about it. R64 stated they were crying about the room change at the time, R64 stated this is the long-term care end, I do not plan on being here long term and I am no longer receiving therapy. On 10/30/24 at 01:08 PM, during an interview with R64, they reiterated that they were not in agreement to the room change, this is the long-term care section, and I was removed from the rehab side. I never wanted to stay here long term. I was very upset when I was moved and cried a lot. On 10/30/24 at 01:50 PM, record review of the EMR (electronic medical record) revealed a notification of room change form, dated 6/17/24. The room change notification states written notification was provided to R64 and section H (reason for the change) of the form indicates, other was the reason for the room change. On 10/30/24 at 01:59 PM, an interview was conducted with SW (social worker) S. SW S was asked if residents must accept a room change or can they refuse to move. SW S stated that residents can refuse a room change and stay where they are at. SW S was asked if R64 was upset that they had to change rooms. SW S stated they did not recall the resident being upset with him or the room change. SW S stated they would follow up with R64 about the room change. On 10/30/24 at 03:25 PM, record review of the EMR revealed SW S met with R64 on 10/30/24 at 14:58 PM (2:58 PM) and R64 stated again they are unhappy with their current placement in the room. Review of the policy titled, Room Change/Roommate Assignment revised May 2017, revealed: 5. Residents have the right to refuse to move to another room in the facility if the purpose of the move is: (continued on next page)

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	235250	A. Building B. Wing	10/31/2024

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. To relocate the resident from a skilled nursing unit within the facility to one that is not a skilled nursing unit; b. To relocate the resident from a nursing unit within the facility to one that is a skilled nursing unit; or c. Solely for the convenience of the staff.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to complete advance directives for seven residents (R19, R24, R29, R30, R36, R39, R50) of seven residents reviewed for advance directives, resulting in missing or incomplete advance directive forms. Findings include: Resident #19 (R19): R19 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cerebral palsy, dysphagia, anxiety disorder and need for assistance with personal care. R19 has a Brief Interview for Mental Status (BIMS) score of 13, indicating they are cognitively intact. R19 has a guardian due to the inability to make their own medical decisions. On [DATE] at 10:53 AM, record review of the EMR (electronic medical record) for R19 revealed a physician's order for CPR (cardiopulmonary resuscitation), there is an advance directive care plan in place, no signed documents indicating code status were able to be located. Resident #24 (R24): R24 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure, chronic obstructive pulmonary disease, anxiety disorder and hypertension. R24 has a BIMS score of 14, indicating they are cognitively intact. On [DATE] at 01:52 PM, record review of the EMR for R24 revealed a physician's order for CPR, there is an advance directive care plan in place, no signed documents indicating code status were able to be located. Resident #29 (R29): R29 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic kidney disease, major depressive disorder, hypertension and hemiplegia and hemiparesis following a cerebral infarction. On [DATE] record review of the EMR for R29 revealed a physician's order for CPR, a care plan for advanced directive. An advance directive form dated [DATE] was located in the EMR, it contained one signature from a staff member and none of the boxes were checked indicating the code status R29 wished to receive. Resident #30 (R30): R30 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include heart failure, history of pulmonary embolism, dependence on oxygen and obstructive sleep apnea. R30 has a BIMS of 14 indicating they are cognitively intact. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:02 AM, record review of the EMR for R30 revealed a physician's order for full code by default (the code status given when an advance directive hasn't been chosen) dated [DATE], there is an advance directive care plan in place, no signed documents indicating code status were able to be located. Resident #36 (R36): R36 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include adult failure to thrive, anxiety disorder, dysphagia and muscle weakness. R36 has a BIMS of 14, indicating they are cognitively intact. On [DATE] at 10:46 AM, record review of the EMR for R36 revealed a physician's order for CPR, and advance directive care plan was in place, no signed documents were located indicating code status. Resident #39 (R39): R39 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include type two diabetes, difficulty in walking, dysphagia and urine retention. R39 has a BIMS score of 9, indicating they have moderate cognitive impairment. R39 is alert and able to answer questions. On [DATE] at 10:26 AM, record review of the EMR for R39 revealed a physician's order for CPR, an advance directive care plan is in place, no signed documents indicating code status could be located. Resident #50 (R50): R50 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include left tibia and left fibula fracture, muscle weakness, anxiety disorder and a history of falling. R50 has a BIMS score of 11, indicating moderate cognitive impairment. On [DATE] at 10:37 AM, record review of the EMR for R50 revealed a physician's order for full code by default, an advance directive care plan was present, unable to locate signed documents indicating the code status chosen. On [DATE] at 02:24 PM, an interview was conducted with SW (social worker) J. SW J indicated they are responsible for discharge planning at the facility. SW J was asked if the facility has a form that is signed by the guardian, responsible party or resident that is uploaded to the EMR to indicate advance directives. SW J stated yes, there is supposed to be a form that is uploaded with the code status decision on it. SW J was asked to locate a form in the EMR and was unable to do so. On [DATE] at 02:30 PM an interview was conducted with SW S. SW S was asked if there is a form that is uploaded into the EMR and signed for code status on admission. SW S indicated that on admission residents fill out a form that is supposed to be completed and uploaded to the EMR to indicate advance directives. SW S was asked how long after admission is a reasonable timeframe to get the code status form completed. SW S stated the process occurs on admission, nursing fills out the advance directive form with the resident, responsible party or guardian. SW S stated they would have to check with nursing to see how long that takes to complete that process. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:43 AM: SW S indicated they are still trying to locate the signed advance directive forms for the residents that were requested. Review of the policy titled, Advance Directives/Advance Care Planning reviewed ,d+[DATE], revealed: Policy Interpretation and Implementation 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives and applicable state law. 3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. 4. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information. 5. Each resident will also be informed that the facility's policies do not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive. 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37668 Based on interview and record review, the facility failed to provide adequate notice of non-coverage and maintain documentation for two residents (Resident #76 and Resident #187) of five residents reviewed resulting in the lack of full disclosure related to Medicare rights and inability to appeal the discharge in the time frame allotted by Medicare. Findings include: Resident #76: Review of Resident #76's Notice of Medicare Non-Coverage Form revealed the Resident's current services would end on 7/21/24. The form was signed by the Resident on 7/21/24. Resident #187: Per the facility completed, Beneficiary Notice- Residents discharged Within the Last Six Months form, Resident #187's discharge date was 7/1/24. The Resident's Notice of Medicare Non-Coverage Form was requested from the facility and not provided. An interview was completed with Social Worker J and Social Services Director S on 10/29/24 at 12:39 PM. When queried regarding Resident #187's Notice of Medicare Non-Coverage Form, Social Worker J stated they can't find the form. An interview was completed with the facility Administrator on 10/31/24 at 10:46 AM. The Administrator revealed they were aware of the missing notification form for Resident #187. When asked, the Administrator indicated the forms should be provided at least 48 hours prior to discharge and should be maintained as part of the medical record. No further explanation was provided.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to complete continued assessment and monitoring for physical restraints for one resident (Resident #75) of one resident reviewed for restraints, resulting in Resident #75 having a chest harness with four non-self-release buckles. Finding Include: Resident #75: During initial tour on 10/28/2024 at 1:20 PM, Resident #75 was observed in the common area with other residents and staff. He was seated in a customized chair with a harness seatbelt, that secures in four spots. It did not appear Resident #75 would be able to remove the harness himself. On 10/28/2024, at approximately 1:25 PM, a review was conducted of Resident #75's medical record and it indicated he admitted to the facility on [DATE] with diagnoses that included Cerebral Palsy, Acute Respiratory Failure, Dysphagia, Hypertension and Chronic Obstructive Pulmonary Disease. Further review yielded the following: Physician Order: Custom w/c with custom molded seat back as well as postural chest harness with removable buckles and seat belt for safety and tactile sensory support when in w/c. Remove postural chest harness with care for skin checks each shift. Ordered on 4/19/2024 and discontinued on 6/13/2024. It can be noted Resident #75 was admitted to the facility on [DATE] without assessment, continued monitoring or consent for usage. Upon readmission in July 2024 there were no orders or consistent monitoring/assessment by nursing completed. Care Plan: .Custom w/c (wheelchair) from home with custom seat and torso harness for postural support and stability . Progress notes: 4/19/2024 at 15:38: Reviewed custom w/c with custom molded seat back and postural chest harness with removable buckles and seat belt for safety with Mother/Guardian. Reviewed residents' abilities and inability to unbuckle part of the harness . 4/19/2024 at 12:22: OT (occupational therapy) evaluation of custom w/c with custom molded seat back and seat as well as postural chest harness with removable buckles and seat belt for safety and tactile sensory support when in w/c completed. Resident continues to require postural chest harness for upper body truncal support when in wheelchair. Orders obtained to remove harness with care for skin checks . (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	4/29/2024 at 9:32: pt (patient) is a [AGE] year (old) gentleman with h/o cerebral palsy since birth he is non verbal and has peg tube for nutrition he has postural instability and need a chest harness with removable buckle and seat belt resident can release the seat belt only on command he has utilized it for years and help hi posture without any side effects at this time it would be beneficial to jeep the harness on for his postural stability as it has caused no harm. It can be noted the progress notes contradict one another regarding Resident #75 having the functional ability to release the seatbelt and harness fasteners. MDS (Minimum Data Set) Assessment: Section P: Physical restraints are any manual method of physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to ones' body. Resident #7 physical restraint use is coded as not used, under this section. On 10/29/2024 at 9:53 AM, Resident #75 was observed in his chair with his chest harness secured. Unit staff were asked if Resident #75 was able to release himself from the harness and they stated, No. On 10/29/2024 at 4:00 PM, an interview was conducted with Therapy Director Y regarding Resident #75's harness. Director Y was asked if Resident #75 was able to release any of the four fasteners to release himself ad she stated he was not. The orders were reviewed and there was none found for the resident. Review was completed of the Occupational Evaluation/Encounter Notes: 4/17/2024: .Resident readmitted to the SNF (skilled nursing facility) 11/2023 from hospital with new PEG tube placed .Resident does have a custom w/c with custom molded seat back ad seat as well as postural chest harness with removable buckles and seat belt for safety and tactile sensory support when in w/c . Upon request resident is able to unbuckle seat belt however does not exhibit the dexterity to manage the smaller chest harness buckles, requiring assist from staff for appropriate alignment . 7/4/2024: .W/C mgmt.: assessment of current seating system for appropriate modifications with noted tolerance and fit of custom seating system .Resident is unable to propel w/c this date with tactile's and visual cues to use wheels and maneuver as previously able . 9/25/2024: Quarterly screen completed. No noted change in postural status or positioning. d/c from PT/OT services. Custom wc with custom seat and torso harness . MDS Coordinator V was asked what the definition of a restraint is for coding purposes. She reported it would anything that a resident cannot remove themselves. Coordinator V was the asked if any residents in the facility are coded as such and she responded, No. The coordinator was asked about Resident #75, and she expressed they met at a team, had his physician complete an order and progress note and a care planned intervention as well. Coordinator V reviewed Resident #75's physician notes and stated the order was not put in again upon his readmission to the facility. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Throughout the annual survey the facility restraint policy was requested multiple times. The administrator reported they do not have a physical restraint policy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to ensure that reviews and revisions of residents' care plans were made to ensure interventions necessary for care and services were provided for 5 residents (#5, #9, #40, #78, #80), resulting in a lack of showers/bathing, weight loss and/or catheter care, consistently resulting in the potential for unmet care needs. Findings include: Resident #5: Activities of Daily Living: In an interview on 10/28/24 at 10:40 AM with Resident #5 stated that she does have missed her showers. The Resident #5 stated that she requested showers 3 days a week, like she would if she was at home. But the staff will miss her shower day and if she does not remind them and then [NAME] the aides, they will not do it. Record review of Resident #5's Activity of Daily Living (ADL) care plan dated 7/18/2024 noted bathing with 2 assists, prefers to have showers Monday-Wednesday-Fridays. Record review of Resident #5's shower task question #3: Shower, bed bath or tub, 30-day look back revealed that Resident #5 only received seven (7) showers in 30 days. Record review of Resident Kardex care guide used by Certified Nurse Assistants (CNA's) noted: Shower/bed bath Monday, Wednesday, Fridays on 1st shift and PRN (as needed). Urinary Catheter: In an interview on 10/28/24 at 12:20 PM with Resident #5 revealed that her Supra pubic urinary catheter doesn't get changed as it should, and she has to tell staff to change the catheter. Resident #5 stated that the suprapubic catheter is supposed to come up on the computer, but it doesn't. It didn't get changed as it should. Resident #5 stated that the suprapubic catheter care doesn't get done regularly. Record review of Resident #5's Kardex care guide dated 10/28/2024 revealed Certified Nurse Assistant to provide catheter care each shift and as needed, record urine output each shift. Record review of Resident #5's Catheter care/output/kink each shift (3 times daily) checks task form 30 day look back revealed catheter care was given: No documented catheter care or output on: October 6th, 7th, 8th, 10th, 12th, 13th, 15th, 17th, 18th, 19th and 23rd. Catheter care given one time a day: 2nd, 3rd, 11th, 16th, 20th, 21st, 22nd, 24th and 30th. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Catheter care two times daily: 1st, 4th, 27th, and 29th. Catheter care given 3 times daily: 9th, 14th, 25th, 26, and 28th. Resident #9: Nutrition: In an interview on 10/28/24 at 10:27 AM with Resident #9 revealed that he had lost weight, and he doesn't know why. Resident #9 stated that he does have a peg tube that they feed him with. Record review of Resident #9's weight log noted a weight on 10/2/24 of 147.2 pounds and on weight on 10/18/24 of 130.1 pounds, that is a 17.1-pound weight loss or 11.62% weight loss. Record review of Resident #9's tube feeding care plan dated 8/15/2024 revealed tube feeding as ordered by registered dietitian. No rate was documented on the care plan. There were no added interventions noted after the 10/18/2024 weight loss. Resident #40: Activities of Daily Living: In an interview on 10/28/24 at 09:46 AM with Resident #40 revealed that the shower chairs do not fit the resident, the facility has a blue reclining shower chair. There is no shower bed, and staff tell (the resident) that the tub is broken, so she gets a bed bath or only half a shower because the shower chair does not fit in the shower. Record review of Resident #40's care plans for activities of daily living (ADL) revealed that the resident required physical assist of two staff members with repositioning, toileting, mechanical transfers, dressing, and bathing/showers. Record review of Resident #40's shower/bathing task form 30-day look back from 10/1/2024 through 10/27/2024 revealed only three (3) showers/bathes were given to a totally dependent upon staff resident. Resident #78: Activities of Daily Living: In an interview on 10/29/24 at 02:25 PM with Resident #78 revealed that he did not know how often he gets a shower/bath stating not very often, and he did not know why. Resident #78 stated that They just give him a washcloth and to wash up in the room. Record review of Resident #78's Activity of Daily Living (ADL) care plan dated 7/8/2024 revealed the resident needed assistance with one staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #78's shower/bathing Monday and Thursday task form 30-day look back 9/30/2024 through 10/30/2024 revealed only three (3) showers/bathes given on 10/3/24, 10/7/24 and 10/14/24. Resident #80: Activities of Daily Living: Observation on 10/29/24 at 09:04 AM of Resident #80 Appeared un-shaven and scruffy in appearance and thin. In an attempted interview on 10/29/24 at 02:27 PM with Resident #80 made eye contact and shook his head to surveyor questions. Resident #80 responded with slow speech that they just wash me up in bed, its cold. Record review of Resident #80's Activity of Daily Living (ADL) care plan intervention dated 3/17/2024 revealed Resident #80 required assistance of 2 staff with shower/bathing. Record review of Resident #80's shower/bathing every Tuesday and Sunday on 2nd shift, 30-day look back 9/30/24 through 10/30/24 revealed only 3 showers/bathes: On 9/30/24, 10/10/24 and 10/20/24. Record review of the facility 'Care Plan, Comprehensive Person-Centered' policy dated 3/2023 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. (11.) Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change. (12.) The interdisciplinary team reviews and updates the care plan: (a.) when there has been a significant change in the resident's condition. (b.) When the desired outcome is not met. (c.) When the resident has been readmitted to the facility from a hospital stay; and (d.) at least quarterly, in conjunction with the required quarterly MDS assessment. Record review of facility 'Bath-Shower' policy dated 2/2024 revealed care plan guidelines to list the amount of assistance the resident needs with bathing and any resident preferences, precautions, special soap or lotion to be used, etc.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Numbers MI00147548 and MI00147625. Based on observation, interview and record review the facility failed to document and provide routine showers and hygiene care for 12 residents (#5, #9, #24, #40, #50, #56, #57, #64, #72, #76, #78, #80) of 12 residents reviewed and 7 of 12 residents from confidential Resident Group meeting, resulting in residents' feelings of embarrassment from poor hygiene, and frustration. Findings Include: During a confidential Resident Council meeting held on 10/29/2024 at 11:30 AM, the twelve residents in attendance were queried regarding the care provided to them at the facility. Seven residents stated they were not consistently receiving their showers. Residents stated they had not received showers in two weeks and were not provided with a reason as to why. They expressed frustration as they felt disregarded. Resident #57: During initial tour on 10/28/2024, Resident #57 was observed resting in bed while. Review was completed of her medical record, and it revealed she initially admitted to the facility on [DATE] with diagnoses that included, Bipolar Disorder, Alcohol Abuse, Major Depression, Generalized Anxiety and Diverticulosis. Review was completed of Resident #57's showers over the last 30 days and it indicated the resident received one shower on 10/8/2024. Resident #72: During initial tour on 10/28/2024, Resident #72 was observed in the common area with consistent movement of standing up then back down. She was not able to be interviewed due to her disease process. On 10/29/2024 at 4:50 PM, a review was conducted of Resident #72's medical record and indicated the resident admitted to the facility on [DATE] with diagnoses the included. Dementia, Schizoaffective, Major Depressive Disorder and traumatic brain injury. Further review of Resident #72's chart yielded the following: Care Plan: .I have an ADL self-care performance deficit related to impaired cognition and mobility . BATHING/SHOWERING: I require extensive assistance by (1) staff with bathing/showering . Review was completed of Resident #57's showers over the last 30 days and it indicated the resident received two showers (10/3/24 and 10/6/2024) during the lookback period. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/31/24 at 08:23 AM, The administrator was questioned regarding resident showers being completed as scheduled. The administrator reported she believed facility staff are showering residents but there is an issue with documentation. She explained they have discussed with nurses their responsibility to hold aides accountable for ensuring resident cares are completed and subsequent documentation. They have found the nurses are apprehensive to directly address the aides when oversights occur. 37668 Resident #56: On 10/28/24 at 11:10 AM, Resident #56's room door was observed to be closed. Upon knocking and entering the room, a pungent, foul odor with overwhelming putrid qualities was immediately noted. The smell grew stronger closer to the Resident. The Resident was laying in bed with their knees bent wearing a hospital style gown. Their hair was uncombed with a greasy appearance. A large amount of personal food items, including nutritional shakes and candy, as well as condiments packets were present in various areas throughout the room. When queried regarding the food items present, Resident #56 revealed their family brings it to them. Resident #56 verbalized that the facility kitchen always sends tea and they do not like tea without sugar so that keep packets in their room. Resident #56 was asked how they transfer and get out of bed and revealed they are unable to walk, and staff have to transfer them with the Hoyer lift (mechanical lift used for transferring from surface to surface). When queried regarding bathing and showering, Resident #56 replied, Only shower once a week. When queried regarding other bathing assistance, Resident #56 indicated the staff provide incontinence care when they ask them. Resident #56 was then asked if they are satisfied with having one shower a week, Resident #56 revealed they did not want to want to bother the staff. When asked what they meant, Resident #56 indicated the staff are busy and it is harder for them to get them out of bed because of the lift so they do not complain. Resident #56 was asked if they would like to shower more and revealed they would it they need it. At 11:18 AM, Certified Nursing Assistant (CNA) U entered Resident #56's room. CNA U assisted the Resident to roll to their right side to provide care. After rolling onto their side, a wound on the Resident's upper left back was visualized. An undated was dressing was in place but did not cover the entire wound bed. Dark colored wound drainage was present on the bedding where the Resident had been laying. Record review revealed Resident #56 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), diabetes mellitus, open wound, and difficulty walking. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required moderate to total assistance to completed Activities of Daily Living (ADL) with the exception of oral hygiene and eating. Review of Resident #56's Electronic Medical Record (EMR) revealed a care plan entitled, have an ADL self-care performance deficit related to altered mobility . I choose to keep a multitude of items on my bedside table, combining edible and non-food items (Initiated: 8/3/24; Revised: 10/29/24). The care plan included the intervention, Bathing/Showering: require assistance by (2) staff for bathing/showering. Use a lift to transfer to shower chair (Initiated: 8/3/24; Revised: 9/23/24). On 10/31/24 at 11:50 AM, Resident #56 was observed sitting in their wheelchair. The Resident's hair was uncombed with a greasy, dirty appearance. Resident #76: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/28/24 at 12:19 PM, Resident #76 was observed laying on their back in bed in their room. The Resident was wearing a visibly soiled blue long sleeve shirt with significant amounts of chunks of unknown substances on it. The Resident was unshaven and had an unkept appearance. Resident #76 was tall, and both of their feet were noted to be pressed against the footboard of the bed. The Resident did not have a bed extension in place. Resident #76's left upper arm was positioned by their side in bed. Their arm was discernibly edematous, and their hand was positioned in a fist. When queried, Resident #76 revealed they had a stroke which effected their left side. When queried if they were able to move their left arm and hand, Resident #76 indicated they could not. The Resident's fingernails were observed to be long and unkept with sharp edges and had a buildup of dark colored unknown substances under the nails. When queried how they get out of bed, Resident #76 revealed staff transfer them using the Hoyer (mechanical) lift. Resident #76 was asked how often they get out of bed and revealed they do not get up often. When queried regarding the care they receive at the facility, Resident #76 stated, This place is terrible. When asked why, Resident #76 replied, The aides have attitude. Resident #76 was asked how the aides have attitude and replied, They tell me it's not their job when they ask for help. When queried regarding bathing and showers, Resident #76 revealed staff have told them that it is to difficulty to get them up and that they do not have enough staff, so they usually end up just getting a bed bath. Resident #76 revealed they do not always get bed baths and stated, The one lady wouldn't give me a bed bath - she told me that wasn't her job. When asked if another staff member assisted them to wash up/gave them a bed bath, Resident #76 revealed they did not. Resident #76 was asked how often they would like a shower and revealed more often than they receive. When queried how often they showered prior to coming to the facility, Resident #76 revealed they showered daily. Resident #76 then disclosed their career and the importance of good hygiene and cleanliness. When queried regarding their fingernails, Resident #76 revealed staff do not assist and/or provide fingernail care routinely. Record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses which included left sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarct (stroke), heart failure, diabetes mellitus, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to total assistance to complete all ADL'S. On 10/30/24 at 10:39 AM, an observation of care for Resident #76 was completed with Certified Nursing Assistant C. An observation of Resident #76's feet revealed the Resident's toenails were thick, discolored, and overgrown. The toenails on both of the Resident's feet were curved around the end of their toes. When queried when they last had their toenails addressed and/or were seen by podiatry services, Resident #76 revealed they were not sure and had not been seen by a podiatrist. An interview and observation of Resident #76's toenails was completed with Unit Manager Registered Nurse (RN) CC on 10/30/24 at 11:00 AM. When queried regarding the condition of the Resident's toenails, RN CC verbalized the Resident's toenails needed to be addressed and they would see about getting them seen by a podiatrist. Review of Resident #76's EMR revealed a care plan entitled, I have an ADL self-care performance deficit elated to . and generalized weakness (Initiated: 6/20/24; Revised: 7/2/24). The care plan included the interventions: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Bathing/Showering: I require assistance by (2) staff with bathing/showering (Initiated: 6/20/24; Revised: 6/21/24) Resident #76 did not have a care plan in place related to finger and/or toenail care. Review of task documentation in Resident #76's EMR revealed the task, Shower/Bed Bath Monday and Thursday 1st shift but did not distinguish Resident preference nor did it reflect that the Resident received showers twice a week. 49944 Resident #24 (R24): R24 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure, chronic obstructive pulmonary disease, anxiety disorder and hypertension. R24 has a BIMS score of 14, indicating they are cognitively intact. On 10/29/24 at 04:00 PM, R24 stated that the nursing staff give her a hard time about taking a shower. R24 was asked if this happens all the time. R24 stated that they gave the staff one day off from giving her a shower because they were busy and now, they have taken liberty with it. R24 stated they believe the nursing staff will hide out and not shower her, the staff always says they are busy. On 10/30/24 at 11:05 AM, record review of the EMR (electronic medical record) for R24 revealed they have had three baths/showers completed in the last 30 days. Record review further revealed that R24 has three shower refusals, and three times staff has not documented/offered a shower on 9/30, 10/7 or 10/14. On 10/30/24 at 11:07 AM, record review of the ADL (activities of daily living) care plan, dated 01/21/2023, revealed R24 requires assistance with one staff for shower/bathing. Resident #50 (R50): R50 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include left tibia and left fibula fracture, muscle weakness, anxiety disorder and a history of falling. R50 has a BIMS score of 11, indicating moderate cognitive impairment. On 10/29/24 at 10:31 AM, observation revealed R50 was well dressed, groomed, the scent of urine is noted while sitting beside the resident. On 10/29/24 at 11:16 AM, record review revealed that R50 has only had four showers in the last 30 days. Documentation revealed that one shower was refused. Nothing was documented on 10/6, 10/20 or 10/27. On 10/30/24 at 11:17 AM, record review of the ADL care plan, dated 07/05/2024, revealed R50 is a one staff assist for showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/30/24 at 12:57 PM, R50 was asked if it was accurate that they had only received four showers in the last 30 days. R50 said that is probably true. R50 was asked about the other potential dates for the month that they didn't receive a shower. R50 stated they just didn't give them to me, I will never refuse a shower. Resident #64 (R64): R64 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following a cerebral infarction, muscle weakness, hypertension and muscle wasting. R64 has a BIMS score of 15, indicating they are cognitively intact. On 10/30/24 at 01:00 PM, an interview was conducted with R64. R64 was asked if they ever refuse showers. R64 stated they have refused showers due to the COVID outbreak a while back, stating they were afraid to leave the room. R64 stated they received a bed bath during COVID. R64 was asked if it was accurate they had only received 4 showers in the last 30 days. R64 stated the staff never offered showers for the other days of the month that were missed. R64 stated they don't want a shower from someone that doesn't want to give it anyhow, I will not beg them. R64 stated the staff know my schedule and if they wanted to do it then they would've. R64 stated in the previous room there was a shower and no need to leave it to get a shower completed. On 10/30/24 at 01:10 PM, record review revealed that R64 has only had 4 showers in the last 30 days. Four showers were documented as given, one was refused, and no documentation was noted on 9/30, 10/3, 10/7 and 10/14. On 10/30/24 at 01:15 PM, record review of the ADL care plan, dated 05/01/2024, revealed that R64 requires assistance of one staff for shower/bathing. 22927 Resident #5: Activities of Daily Living: In an interview on 10/28/24 at 10:40 AM with Resident #5 stated that she does have missed her showers. The Resident #5 stated that she requested showers 3 days a week, like she would if she was at home. But the staff will miss her shower day and if she does not remind them and then [NAME] the aides, they will not do it. Record review of Resident #5's Activity of Daily Living (ADL) care plan dated 7/18/2024 noted bathing with 2 assists, prefers to have showers Monday-Wednesday-Fridays. Record review of Resident #5's shower task question #3: Shower, bed bath or tub, 30-day look back revealed that Resident #5 only received seven (7) showers in 30 days. Record review of Resident Kardex care guide used by Certified Nurse Assistants (CNA) noted: Shower/bed bath Monday, Wednesday, Fridays on 1st shift and PRN (as needed). Resident #9: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Activities of Daily Living: In an interview on 10/29/24 at 02:22 PM with Resident #9 revealed that he was not getting showers, and that they just wash him up in bed. Resident #9 stated he would rather have a shower with warm water and a good scrubbing. Record review of Resident #9's care plans for activities of daily living (ADL) revealed that the resident required physical assist of two staff members with repositioning, toileting, mechanical transfers, dressing, and bathing/showers. Record review of Resident #9's shower/bathing on Wednesday and Saturdays task form 30-day look back from 10/1/2024 through 10/27/2024 revealed only two (2) showers/bathes were given to a totally dependent upon staff resident. Resident #40: Activities of Daily Living: In an interview on 10/28/24 at 09:46 AM with Resident #40 revealed that the shower chairs do not fit the resident, the facility has a blue reclining shower chair. There is no shower bed, and staff tell (the resident) that the tub is broken, so she gets a bed bath or only half a shower because the shower chair does not fit in the shower. Record review of Resident #40's care plans for activities of daily living (ADL) revealed that the resident required physical assist of two staff members with repositioning, toileting, mechanical transfers, dressing, and bathing/showers. Record review of Resident #40's shower/bathing task form 30-day look back from 10/1/2024 through 10/27/2024 revealed only three (3) showers/bathes were given to a totally dependent upon staff resident. Resident #78: Activities of Daily Living: In an interview on 10/29/24 at 02:25 PM with Resident #78 revealed that he did not know how often he gets a shower/bath stating not very often, and he did not know why. Resident #78 stated that They just give him a washcloth and to wash up in the room. Record review of Resident #78's Activity of Daily Living (ADL) care plan dated 7/8/2024 revealed the resident needed assistance with one staff. Record review of Resident #78's shower/bathing Monday and Thursday task form 30-day look back 9/30/2024 through 10/30/2024 revealed only three (3) showers/bathes given on 10/3/24, 10/7/24 and 10/14/24. Resident #80: Activities of Daily Living: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/29/24 at 09:04 AM of Resident #80 Appeared un-shaven and scruffy in appearance and thin. In an attempted interview on 10/29/24 at 02:27 PM with Resident #80 made eye contact and shook his head to surveyor questions. Resident #80 responded with slow speech that they just wash me up in bed, its cold. Record review of Resident #80's Activity of Daily Living (ADL) care plan intervention dated 3/17/2024 revealed Resident #80 required assistance of 2 staff with shower/bathing. Record review of Resident #80's shower/bathing every Tuesday and Sunday on 2nd shift, 30-day look back 9/30/24 through 10/30/24 revealed only 3 showers/bathes: On 9/30/24, 10/10/24 and 10/20/24.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to conduct and maintain timely activity assessments for eleven residents (#4, #5, #26, #28, #32, #37, #42, #45,#75,#77, #79) of 11 residents reviewed for assessments and ensure that one resident (#4) was able exercise their right to vote of 1 resident reviewed for voting preferences. Findings Include: During Resident Council meeting held on 10/29/2024 at 11:30 AM, Resident #4 shared she would like to vote in the upcoming Presidential election and does not recall this being addressed with her. On 10/29/2024 at 2:35 PM, Activities Director R was queried regarding the process for residents voting in the upcoming election. Director R explained upon admission each resident is asked about their preference regarding voting. When asked about Resident #4, the Director stated during their voting preference audit in September 2024, she declined to vote and recently informed her that her mother would assist with her voting. Director R was asked if there was any follow up that was completed to ensure this was completed and she stated it was not. There was no documentation related to steps taken to ensure the resident was able to carry out her interest in voting. Activities Director R specified within the assessment where voter preferences were located. Resident #4 assessment was reviewed, and it indicated upon admission her desire to vote. During review of her assessments, it was noticed their only Activity Assessment from was admission in May 2024. Director R was asked regarding this and explained activity assessments are only completed upon admission, with significant change and annually; quarterly assessments are not completed. On 10/29/2024 at approximately 2:55 PM, the administrator was asked what the frequency of activity assessments are. The administrator stated they were quarterly but will provide the policy. On 10/30/2024 at approximately 8:00 AM, a review was completed of Resident #4's medical record and it indicated the resident was admitted to the facility on [DATE] with diagnoses that included, Multiple Sclerosis, Protein Calorie Malnutrition, Depression, Paraplegia and Anxiety. Resident #4 can make her needs known and is her own person. Further review yielded the following: Activity Assessments: Admission assessment in 5/2024 completed- there were no other assessments. The assessment indicated Resident #4 is registered and interested in voting On 10/30/2024 at 3:40 PM, Activities Director R explained she was not aware that quarterly activity assessments were a requirement or she would have been completing them. A subset of residents were reviewed for frequency of Activity Assessments and it showed quarterly assessments were not being completed for facility residents as follows: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 had no activity assessments completed since admission in 9/2021 that were documented under assessments tab. Resident #26 had one assessment completed on 6/13/2024 with readmitted [DATE]. Resident #28 had on assessment completed on 10/26/2024 with readmitted [DATE]. Resident #32 had one assessment completed in 3/2024. Resident #37 had assessments completed on 9/12/2024, 10/18/2023 and 10/16/2024. Resident #42 had one assessment completed on 6/5/2024. Resident #45 had one assessment completed on 5/29/2024. Resident #75 had one assessment completed on 12/12/2023 with initial admission to the facility. Resident #77 assessment was completed on 1/18/2024 upon admission. Resident #79 assessment was completed on 2/22/2024 upon admission. Review was completed of the facility policy entitled, Voting Rights, reviewed 1/24. The policy stated, Residents are encouraged to exercise their right to vote in local, state and national elections. The facility will help residents expressing a desire to exercise their right to vote achieve that right . Review was completed of the facility policy entitled, Activity Evaluation, reviewed 1/24. The policy stated, .an activity evaluation is conducted and maintained for each resident as least quarterly and with any significant change of condition that could affect his/her participation in planned activities .The activities director is responsible for completing, directing and/or delegating the completion of the activities component .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility 1) Failed to ensure quality of care to meet residents' needs for diabetic and behavioral care and 2) Failure of facility staff to retrieve medications from the backup source for 11 Residents (#5, #9, #41, #46, #50, #56 #72, #76, #81, #137, #147), resulting in the lack of identification and assessment of changes in condition and delays in treatment. Findings include: Record review of the facility 'Medication Administration' policy dated 11/2023 revealed medications are administered in a safe and timely manner, and as prescribed. (7.) Medications are administered within one (1) hour of their prescribed time, unless otherwise specified Record review of the facility 'Insulin Administration' policy dated 1/2024 revealed characteristics and types of insulin noted three key characteristics of insulin are: Onset of action- (a.) how quickly the insulin reaches the bloodstream and begins to lower blood glucose. (b.) Peak effects- the time when the insulin is at its maximum effectiveness. (c.) Duration of effects the length of time during which the insulin id effective. Resident #5: Observation on 10/28/2024 at 10:30 AM of Registered Nurse/Infection Preventionist P was observed to draw up insulin and enter Resident #5's room. In an interview on 10/28/24 at 10:40 AM with Resident #5 stated that she just received her morning insulin which was to be given before breakfast just now at 10:30 AM. Resident #5 stated that her medications are late a lot of the time. Record review of Resident #5's October 2024 Medication Administration Record (MAR) for the date of 10/28/2024 revealed: Lispro insulin subcutaneous solution pen-injector 100 units/ml, inject 9 units subcutaneously three times a day related to type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema. Administration times: 8:00 AM, 12:00 PM and 5:00 PM. Record review of Resident #5's October 2024 Medication Administration Record (MAR) for the date of 10/28/2024 revealed: Lantus insulin subcutaneous solution pen-injector 100 units/ml, inject 14 units subcutaneously two times a day related to type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema. Administration times: 8:30 AM and 8:30 PM. Record review of Resident #5's diabetes mellitus type 1 with diabetic neuropathy and polyneuropathy care plan revealed nursing interventions of accu-check and insulin as ordered, staff to administer dated 5/2/2023, may use resident's personal Dexcom blood glucose monitor for blood glucose monitoring dated 2/23/2024 were some of the interventions listed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/29/24 at 02:59 PM with Registered Nurse/Infection Preventionist P RN/IP was working the Bay unit medication cart on 10/28/24. RN P was asked about Resident #5's Insulin administration was at 10:30 AM but supposed to be given at 8:00 AM. RN/IP P found out that she was working the medication cart at 6:20 AM from a text at home and had to come into work. RN/IP P usually worked at 8 AM. RN/IP P stated that she had just put in 12 days on call, here every day, so in the morning she did not think about checking the text messages. There are a lot of call-ins, RN/IP P was the only unit manager. Licensed Practical Nurse (LPN) M was working the floor only, but when the state people came in LPN M showed up as a manager. RN/IP P stated that she did pass medications late because she did not know the residents and the facility let her know last minute that she was working. RN/IP P would work the night shift to pick-up for staffing call-ins. The Director of Nursing (DON) does work, the corporate consultant is a nurse but does not pick-up floor hours and the Minimum Data Set (MDS) assessment nurse does not work the floor either. All the meds were late, by hours late. In an interview on 10/29/24 at 03:17 PM with the corporate registered dietitian (RD) AA revealed that residents with diagnosis of diabetes should get their insulin consistently, based on when they eat, we give insulin to what the order states. Record review of Resident #5's 'Medication Admin Audit Report' pages 1-72, dated from 10/1/2024 through 10/30/2024 revealed multiple days of late insulin medication administration. Record review of date of 10/28/2024 revealed that Lantus insulin was to be given at 8:30 AM and was administered at 10:30 AM by Registered Nurse P. Record review of Resident #5's 'Medication Admin Audit Report' pages 1-72 revealed multiple days of late insulin administration. Resident #9: In an interview on 10/28/24 at 10:27 AM with Resident #9 in his room revealed that he had lost weight and that he did not know why. Resident #9 stated that he did have a peg tube that that staff used for his formula stuff feed. Resident #9 acknowledged that he was also diabetic and dependent on insulin for blood sugar control. Record review of Resident #9's October 2024 Medication Administration Record (MAR) revealed: Lispro insulin subcutaneous solution per sliding scale subcutaneously every six hours related to type 1 diabetes mellitus. Administration times: 00:00 AM, 06:00 AM, 12:00 PM and 6:00 PM. Record review of Resident #9's weight log revealed weight on 10/2/24 of 147.2 pounds, and on 10/18/24 a weight of 130.1 pounds. That was a 17.1-pound loss in 16 days. Weight loss percentage of 11.62% loss. Record review of Resident #9's diabetes mellitus care plan revealed care plan revision date of 8/29/2024 with latest intervention dated 7/2/2024 of diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness. Record review of Resident #9's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/2/2024 administer Lispro insulin at 6:00 PM, documented administration time was 10/3/2024 at 00:03 AM. (continued on next page)

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	235250	A. Building B. Wing	10/31/2024

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/3/2024 administer Lispro insulin at 00:00 AM, documented administration time was 05:34 AM. 10/4/2024 administer Lispro insulin at 00:00 AM, documented administration time was 04:43 AM. 10/4/2024 administer Lispro insulin at 12:00 PM, documented administration time was 3:12 PM. 10/6/2024 administer Lispro insulin at 6:00 PM, documented administration time was 09:02 PM. 10/10/2024 administer Lispro insulin at 6:00 PM, documented administration time was 08:37 PM. 10/13/2024 administer Lispro insulin at 12:00 PM, documented administration time was 2:19 PM . Multiple days with late insulin. Resident #41: Record review of Resident #41's October 2024 Medication Administration Record (MAR) revealed: Lispro insulin subcutaneous solution per sliding scale subcutaneously three times a day related to diabetes. Administration times: 07:30 AM, 11:30 AM and 4:30 PM. Record review of Resident #41's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/1/2024 administer Lispro insulin at 07:30 AM subcutaneously before meal, documented administration time was 10:45 AM. 10/2/2024 administer Lispro insulin at 07:30 AM subcutaneously before meal, documented administration time was 10:04 AM. 10/2/2024 administer Lispro insulin at 11:30 AM subcutaneously before meal, documented administration time was 1:55 PM. 10/3/2024 administer Lispro insulin at 11:30 AM subcutaneously before meal, documented administration time was 12:34 PM. 10/4/2024 administer Lispro insulin at 11:30 AM subcutaneously before meal, documented administration time was 2:15 PM. 10/5/2024 administer Lispro insulin at 7:30 AM subcutaneously before meal, documented administration time was 8:36 AM. 10/6/2024 administer Lispro insulin at 07:30 AM subcutaneously before meal, documented administration time was 8:32 AM. 10/6/2024 administer Lispro insulin at 11:30 AM subcutaneously before meal, documented administration time was 1:24 PM. 10/7/2024 administer Lispro insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:59 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/11/2024 administer Lispro insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:52 AM. 10/13/2024 administer Lispro insulin at 11:30 AM subcutaneously before meal, documented administration time was 1:28 PM. 10/14/2024 administer Lispro insulin at 07:30 AM subcutaneously before meal, documented administration time was 10:23 AM . Multiple days with late insulin. Resident #46: Record review of Resident #46's October 2024 Medication Administration Record (MAR) revealed: Humalog insulin subcutaneous solution per sliding scale subcutaneously three times a day related to diabetes. Administration times: 08:00 AM, 12:00 PM and 5:00 PM. Record review of Resident #46's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/1/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:28 AM. 10/1/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 1:06 PM. 10/3/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:57 AM. 10/3/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 12:49 PM. 10/4/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 10:55 AM. 10/4/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 2:27 PM. 10/5/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 12:36 PM. 10/5/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 12:36 PM. 10/7/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 8:31 AM. 10/13/2024 administer Humalog insulin at 07:00 AM subcutaneously before meal, documented administration time was 11:06 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/13/2024 administer Humalog insulin at 11:00 AM subcutaneously before meal, documented administration time was 1:45 PM. 10/15/2024 administer Humalog insulin at 07:00 AM subcutaneously before meal, documented administration time was 8:42 AM. 10/17/2024 administer Humalog insulin at 08:00 AM subcutaneously before meal, documented administration time was 4:49 PM. 10/17/2024 administer Humalog insulin at 12:00 PM subcutaneously before meal, documented administration time was 4:49 PM . Multiple days with late insulin. Resident #50: Record review of Resident #50's October 2024 Medication Administration Record (MAR) revealed: Humalog insulin subcutaneous solution per sliding scale subcutaneously three times a day related to diabetes. Administration times: 07:30 AM, 11:30 AM and 4:30 PM. Record review of Resident #50's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/10/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 10:31 AM. 10/10/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 12:42 PM. 10/11/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 11:06 AM. 10/12/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 8:39 AM. 10/13/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 2:14 PM. 10/14/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:10 AM. 10/14/2024 administer Humalog insulin at 011:30 AM subcutaneously before meal, documented administration time was 1:36 PM. 10/17/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:41 AM. 10/20/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 1:19 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/21/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 11:28 AM. 10/22/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:05 AM. 10/24/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:13 AM . Multiple days with late insulin. Resident #56: Record review of Resident #56's October 2024 Medication Administration Record (MAR) revealed: Lantus insulin subcutaneous solution subcutaneously two times a day related to diabetes. Administration times: 08:00 AM and 8:00 PM. Record review of Resident #56's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/1/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration time was 9:47 AM. 10/2/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration on 10/4/2024 time was 9:16 AM. 10/3/2024 administer Lantus insulin at 08:00 PM subcutaneously before meal, documented administration on 10/4/2024 time was 1:17 AM. 10/5/2024 administer Lantus insulin at 08:00 PM subcutaneously before meal, documented administration on 10/6/2024 time was 1:41 AM. 10/6/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration time was 11:09 AM. 10/7/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration time was 9:17 AM. 10/9/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration time was 10:24 AM. 10/10/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration time was 9:36 AM. 10/15/2024 administer Lantus insulin at 08:00 PM subcutaneously before meal, documented administration time was 9:1 PM. 10/16/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration time was 10:35 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/17/2024 administer Lantus insulin at 08:00 PM subcutaneously before meal, documented administration on 10/18/2024 time was 1:15 AM. 10/20/2024 administer Lantus insulin at 08:00 AM subcutaneously before meal, documented administration time was 11:18 AM . Multiple days with late insulin. Resident #81: Record review of Resident #81's October 2024 Medication Administration Record (MAR) revealed: Lispro insulin subcutaneous solution subcutaneously three times a day related to diabetes. Administration times: 08:00 AM, 12:00 PM and 6:00 PM. Record review of Resident #81's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/5/2024 administer Lispro insulin at 07:00 AM subcutaneously before meal, documented administration time was 10:22 AM. 10/6/2024 administer Lispro insulin at 07:00 AM subcutaneously before meal, documented administration time was 8:21 AM. 10/16/2024 administer Lispro insulin at 08:00 AM subcutaneously before meal, documented administration time was 10:19 AM. 10/16/2024 administer Lispro insulin at 12:00 PM subcutaneously before meal, documented administration time was 2:23 PM . Multiple days with late insulin. Record review of Resident #81's October 2024 Medication Administration Record (MAR) revealed: Humalog insulin subcutaneous solution subcutaneously to scale related to diabetes. Administration times: 07:30 AM, 11:30 and 4:30 PM. Record review of Resident #81's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/7/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 10:13 AM. 10/7/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 2:39 PM. 10/9/2024 administer Humalog insulin at 07:30 AM subcutaneously before meal, documented administration time was 9:50 AM. 10/9/2024 administer Humalog insulin at 11:30 AM subcutaneously before meal, documented administration time was 1:41 PM . Multiple days with late insulin. Resident #137: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #137's October 2024 Medication Administration Record (MAR) revealed: Humalog insulin subcutaneous solution subcutaneously to scale related to diabetes. Administration times: 078:30 AM, 12:00 PM, 5:00 PM and 8:00 PM. Record review of Resident #137's 'Medication Admin Audit Report' for the month of October 2024 revealed late insulin documented administration times: 10/18/2024 administer Humalog insulin at 08:00 PM subcutaneously before meal, documented administration on 10/19/2024 time was 1:50 AM. 10/20/2024 administer Humalog insulin at 08:00 AM subcutaneously before meal, documented administration time was 9:52 AM. 10/21/2024 administer Humalog insulin at 08:00 PM subcutaneously before meal, documented administration time was 9:51 PM. 10/27/2024 administer Humalog insulin at 08:00 AM subcutaneously before meal, documented administration time was 9:52 PM. 10/28/2024 administer Humalog insulin at 08:00 AM subcutaneously before meal, documented administration time was 10:04 AM. 10/28/2024 administer Humalog insulin at 12:00 PM subcutaneously before meal, documented administration time was 1:49 PM . Multiple days with late insulin. Record review of facility 'Diabetes-Clinical Protocol' policy dated 4/2024 revealed as part of the initial assessment, the physician will help identify individuals with elevated blood sugar, impaired glucose tolerance, or confirmed diabetes, as well as factors that may influence glucose tolerance. Record review of 'Nursing 2017 Drug Handbook' page 779 Insulin (fixed combinations) noted that to improve glycemic control in patients with diabetes mellitus noted subcutaneous doses within 15 minutes before a meal or 15 minutes after the start of a meal. 37668 Resident #76: Record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses which included left sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarct (stroke), heart failure, diabetes mellitus, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required maximum/substantial assistance for rolling/turning, bathing, and hygiene and total assistance for transferring. The MDS further revealed the Resident was at risk for but did not have any pressure ulcers. A review of Resident #76's Medication Admin Audit Report for 10/1/24 to 10/29/24 revealed the Resident's medications were administered late (greater than one hour before or after scheduled administration time) 199 times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #81: Record review revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, dementia, depression, heart disease, and left leg below the knee amputation. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required partial to total assistance to complete all ADL with the exception of eating. An interview was completed with Social Services Director S on 10/29/24 at 4:14 PM. When queried regarding Resident #81's psychotropic medications including dosage changes, Director S revealed the Resident's Seroquel (antipsychotic) medication dosage and administration times were changed due to the Resident's behaviors increasing throughout the day. When queried if the Resident had been receiving the medications as ordered and timely prior to the reevaluation and change, Director S indicated they would assume they were but do not administer medications. A review of Resident #81's Medication Admin Audit Report for 10/1/24 to 10/29/24 revealed the Resident's medications, including psychotropic, cardiac, antibiotics, and insulin, were administered late (greater than one hour before or after scheduled administration time) 188 times. 38471 Resident #72: During initial tour on 10/28/2024, Resident #72 was observed in the common area with consistent movement of standing up, then back down. She was not able to be interviewed due to her disease process. On 10/29/2024 at 4:50 PM, a review was conducted of Resident #72's medical record and indicated the resident admitted to the facility on [DATE] with diagnoses the included. Dementia, Schizoaffective, Major Depressive Disorder and traumatic brain injury. Further review of Resident #72's chart yielded the following: Physician Orders: Trazadone HCl Oral Tablet 50 MG (milligram)- Give one tablet by mouth at bedtime for depression. Lorazepam Oral Tablet 0.5 MG- Give one tablet by mouth three times a day related to Schizoaffective disorder, Bipolar type. Progress Notes: Trazadone (antidepressant medication): 10/25/2024 19:13: Orders - Administration Note trazodone HCl Oral Tablet 50 MG Give 1 tablet by mouth at bedtime for depression waiting on delivery from pharmacy. 10/24/2024 20:12: Orders - Administration Note trazodone HCl Oral Tablet 50 MG Give 1 tablet by mouth at bedtime for depression. Waiting to receive from pharmacy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/23/2024 19:32: Orders - Administration Note trazodone HCl Oral Tablet 50 Give 1 tablet by mouth at bedtime for depression. Waiting to receive from pharmacy. 10/20/2024 22:38: Orders - Administration Note Text: trazodone HCl Oral Tablet 50 MG Give 1 tablet by mouth at bedtime for depression. not avail (not available). 10/18/2024 22:19: Orders - Administration Note trazodone HCl Oral Tablet 50 MG Give 1 tablet by mouth at bedtime for depression pharmacy won't fill due to soon. 10/12/2024 18:56: Orders - Administration Note Text: trazodone HCl Oral Tablet 50 MG Give 1 tablet by mouth at bedtime for depression pharmacy wont fill. 10/11/2024 18:42: Orders - Administration Note Text: trazodone HCl Oral Tablet 50 MG Give 1 tablet by mouth at bedtime for depression. Pharmacy states reorder too soon In October 2024 Resident #72 was not administered their trazadone on seven occasions based on nursing progress notes. When compared when the MAR (Medication Administration Record) the medication was not administered eight times during the month due to alleged unavailability. When the medication was available in the backup box. Lorazepam (Anti-Anxiety Medication): 10/22/2024 1829: Orders- Administration Note Text: Lorazepam Oral Tablet 0.5 MG-Give 1 tablet by mouth three times a day. duplicate order not given. 10/10/2024 22:09: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 waiting for pharmacy to send medication. 10/10/2024 15:07: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 MG awaiting c2. 10/10/2024 10:11: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 MG on order awaiting c2. 10/9/2024 22:08: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 MG. waiting for pharmacy to send medication. 10/9/2024 16:34: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 MG. Medication hasn't arrived from pharmacy. No access for back up. Sending c2 doctor will administer once medication arrives. 10/9/2024: 10:53: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 MG. Medication hasn't arrived from pharmacy. No access for back up. Sending c2 to doctor will administer once medication arrives. 10/8/2024 20:06: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 MG. Med not given. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/8/2024 08:03: Orders - Administration Note Text: Lorazepam Oral Tablet 0.5 MG. not available, waiting on pharmacy delivery. In October 2024 Resident #72's was not administered their Lorazepam on nine occasions based on nursing progress notes, when the medication was available in the backup box. On 10/30/2024 at approximately 10:30 AM, a review was conducted of the medications available in their back up box. The following was available: 8-0.5 MG Lorazepam 10-50 MG Trazadone

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Numbers MI00147625, MI00147548, and MI00147423 Based on observation, interview, and record review, the facility failed to implement and operationalize policies and procedures to ensure pressure ulcer prevention and management for five residents (#5, #56, #58, #60, and #76) of eight residents reviewed. This deficient practice resulted in a lack of implementation of meaningful, appropriate, and planned interventions for pressure ulcer prevention, multiple residents developing pressure ulcers, unnecessary pain, and the likelihood for a decline in overall health status. Findings include: Resident #56: On 10/28/24 at 11:10 AM, Resident #56's room door was observed to be closed. Upon knocking and entering the room, a pungent, foul odor with overwhelming putrid qualities was immediately noted. The smell grew stronger closer to the Resident. The Resident was lying in bed on their back with their knees bent and heels/feet directly against the mattress. Resident #56 was wearing a hospital style gown. When queried if they had any wounds or open areas on their skin, Resident #56 revealed they have an open area on their back. With further inquiry, Resident #56 revealed the wound developed at home. When queried regarding wound care provided at the facility, Resident #56 revealed dressing change times are not consistent due to staffing but indicated staff usually change the dressing. When queried if staff remind and/or assist them to turn and reposition in bed every two hours, Resident #56 responded they do not and revealed they do not always see a staff member that frequently. At 11:18 AM, Certified Nursing Assistant (CNA) U entered Resident #56's room. CNA U assisted the Resident to roll to their right side to provide care. After rolling onto their side, a wound on the Resident's upper left back was visualized. An undated was dressing was in place but did not cover the entire wound bed. Dark colored wound drainage was present on the bedding where the Resident had been laying. Record review revealed Resident #56 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), diabetes mellitus, pressure ulcer (wound caused by pressure), and lower extremity contractures. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision/touching assistance for rolling and moderate to total assistance for transferring, bathing, and toileting. The MDS further detailed the Resident had a stage three (full thickness tissue loss pressure ulcer). Review of Resident #56's Electronic Medical Record (EMR) revealed a care plan entitled, I have impaired skin integrity related to admitted with . Stage III pressure ulcer to back . (Initiated: 8/3/24; Revised: 10/22/24). The care plan included the interventions: - Daily skin assessments (Initiated: 8/28/24) - Float my heels while in bed (Initiated: 8/3/24) - Treatments as ordered . (Initiated: 8/4/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- Turn and reposition q (every) 2 h (hours) (Initiated: 8/3/24) - Weekly wound measurement and evaluation (Initiated: 8/3/24) On 10/30/24 at 5:17 AM, 7:39 AM, and 8:14 AM, Resident #56 was observed in their room in bed. For all three observations the Resident was positioned on their back with the heels and feet positioned directly against the mattress. An observation of wound care for Resident #56's left upper back pressure ulcer was completed on 10/30/24 at 11:49 AM with Licensed Practical Nurse (LPN) G. LPN G removed the dressing from the wound bed and a small amount of dark reddish colored drainage was observed. The wound bed was red in color and irregularly shaped. Resident #60: On 10/28/24 at 12:14 PM, Resident #60 was observed lying in bed in their room with their eyes open wearing a hospital style gown. The Resident was laying on their back and slightly on their right side with their lower legs and heels positioned directly against the mattress. The room lights were off, the blinds were closed, and there was no visual and/or audio sensory stimulation. When queried regarding the care they receive at the facility, Resident #60 stated, I got a sore spot on my butt it ain't going away. Resident #60 then stated, Been waiting to talk to nurse about my butt. When asked if the area hurt, Resident #60 responded that it did. An observation of the Resident's room revealed no positioning devices and/or additional pillows for pressure relief. When queried if staff assist them to turn and reposition in bed, Resident #60 shook their head to indicate no. When asked if they are able to turn themselves in bed, Resident #60 repeated that there was a sore spot on their buttocks but did not provide a response to the question. When queried regarding getting out of bed and staff assistance, Resident #60 replied that they cannot walk and do not get up. Record review revealed Resident #60 was admitted to the facility on [DATE] with diagnoses which included dementia, malnutrition, arthritis, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required substantial to total assistance to complete all ADL's with the exception of eating. The MDS further detailed the Resident was at risk for pressure ulcer development but did not have any pressure ulcers. Upon request for a list of Residents with wounds and pressure ulcers, the facility provided a list entitled, Wound Report for 10/23/24. The report detailed Resident #60 had Shearing to right and left buttock that was present upon admission. Review of Resident #60's Healthcare Provider (HCP) orders and Treatment Administration Record (TAR) revealed the Resident had the following active wound care order in place, Cleanse open areas to BL (bilateral) buttocks with wound cleanser. Pat dry. Apply calcium alginate (wound dressing indicated to treat moderate to heavily draining partial to full thickness draining wounds including full thickness tissue loss pressure ulcers, tunneling wounds, and some burns) to wound beds. Cover with a foam dressing. Change every 3 days and PRN (as needed) every night shift every 3 day(s) for wound care (Start Date: 10/9/24). A second active PRN order for the same treatment was present for if dressing missing or soiled (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #60's Completed, Discontinued, On hold, Pending Clinical Review, Pending Confirmation, and Struck out HCP orders revealed the following: - Cleanse open area to left buttock with wound cleanser. Pat dry. Apply Selan cream to open cleanser. Pat dry. Apply Selan cream to open area. Cover with a foam dressing. Change daily and PRN (as needed) . if dressing soiled or missing (Ordered: 9/19/24; Discontinued: 10/9/24) - Cleanse open area to left buttock with wound cleanser. Pat dry. Apply Selan cream to open cleanser. Pat dry. Apply Selan cream to open area. Cover with a foam dressing. Change daily and PRN every night shift . Review of Resident #60's EMR revealed the following Wound Evaluation assessment documentation: - 9/19/24 - 4:07 PM . Coccyx . Present on Admission . Length: 13.21 cm (centimeters). Width: 6.41 cm. Deepest Point: 0.1 cm . Describe: Type Other . Shearing (a contributing factor in pressure ulcers, a wound caused solely by sufficient pressure and force to keep the body moving in one direction - friction) . Wound Age Unknown . Staged by In-house nursing . Wound Bed . Granulation . 100% . Exudate . None . Treatment . Primary Dressing . Selan (zinc oxide barrier cream) Secondary Dressing: Foam . Additional Care: Incontinence management, Mattress with pump, Moisture barrier . Turning/repositioning program . Education Educated resident on the importance of turning and repositioning every 2 hours as tolerated . The wound picture included with the assessment and used to measure the wound showed a large open wound on the right buttocks with irregular borders and a pink/red colored wound bed with areas of black tissue within the wound bed. Two separate, smaller wounds were proximal to the larger wound on the right buttocks. A separate wound was present on the coccyx and left buttocks. The wound bed was irregularly shaped and approximately 45% of the wound bed being composed of dark black and purple tissue, approximately 5% of the wound bed being visible deeper and deep red in color and the other areas of the wound bed pink in color. - 9/24/24 - 1:25 PM . Coccyx . Length: 9.26 cm .Width: 4.46 cm . Deepest Point: 0.1 cm . Describe . Shearing . Granulation . 100% . Exudate . None . Treatment . Primary Dressing . Selan . Secondary Dressing: Foam . Additional Care: Incontinence management . Moisture barrier . Nutrition/dietary supplementation . Turning/repositioning program . Educated resident on the importance of turning and repositioning every 2 hours as tolerated . The wound picture included was taken from a different angle and the wound on the right buttocks was not entirely captured in the picture/measurement. The picture showed the wound on the right buttocks and the coccyx/left buttocks to be completely separate areas not connected by a skin bridge. The two separate, smaller wounds proximal to the wound on the right buttocks were not visible in the image. A white colored substance was present around the coccyx/left buttocks wound edges in the picture. The wound bed was a milky white/pink color with darker area of tissue present at approximately the 7 to 8 o'clock position of the wound bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- 10/22/24 - 11:23 AM . Coccyx Length: 7.5 cm . Width 1.93 cm . Shearing . Wound Bed . Epithelial 50% . Granulation 50% . Exudate: Light . Serous . Treatment . Dressing Appearance: (Prior) Missing . Primary Dressing: Calcium alginate Secondary Dressing: Foam . Additional Care: Cushion, Heel suspension/protection device, Incontinence management, Moisture barrier, Moisture control. Nutrition/dietary supplementation, Turning/repositioning program . Notes resident noted to be lying on right side most of the day and does not like to reposition off the right side; attempts to float heels off bed declined. Education attempted; resident not able to retain information . The attached wound picture included in the assessment was from a different angle than previous pictures. The entire coccyx/left buttocks was not included in the image. The open wound on the right buttocks appeared to have a skin bridge but the wound bed was unable to be completely seen for description due to the angle of the image. The Resident was visibly soiled, and bowel movement was present in the image. - 10/29/24 - 9:22 AM . Coccyx . Length: 7.02 cm . Width: 2.18 cm . Describe . Shearing . Granulation . 100% . Scab . Exudate . Light . Serosanguineous . Treatment . (Prior) Dressing . Missing . Primary Dressing: Calcium alginate Secondary Dressing: Foam . Additional Care: Cushion, Heel Suspension/protection device, Incontinence management, Mattress with pump . Repositioning device(s), Turning/repositioning program . Notes Shearing has improved. One small, superficial scab to left buttock and superficial excoriation to right buttock remains . Education: Attempted but resident cognition is poor . The attached wound picture included in the assessment was from a different angle than previous images and the entire coccyx/left buttocks was not included. The coccyx/left buttocks wound visible in the image was pink in color with an oblong area on dark yellow/light brown colored tissue in the center. The open wound on the right buttocks was unable to be completely visualized due to the angle but appeared to have a skin bridge but the wound bed was unable to be completely seen for description due to the angle of the image. Review of Resident #60's EMR revealed a care plan entitled, I have impaired skin integrity skin impairments to bilateral buttocks r/t mobility and incontinence of bladder and bowel . HX (history) of PI (Pressure Injury) with scar tissue . Risk for friction and shearing . (Initiated: 9/19/24; Revised: 10/15/24). The care plan included the interventions: - Weekly wound measurement and evaluation (Initiated: 9/19/24) - Remind me as needed to move feet and legs to offload pressure (Initiated: 9/19/24; Revised: 10/15/24) - APM mattress (Initiated: 9/19/24; Revised: 10/15/24) - I prefer to not offload pressure as recommended (Initiated: 9/19/24) - Daily skin assessments (Initiated: 9/19/24) - Encourage and assist me to turn and reposition as I tolerate, If I decline attempt small shifts of body. If I decline both reapproach at later time (Initiated: 9/19/24; Revised: 10/15/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #60's care plans revealed the Resident did not have a care plan and/or intervention in place On 10/30/24 at 5:13 AM, Resident #60 was observed in their room from the hallway of the facility. They were uncovered and their brief was visible. The Resident was laying on their back and slightly on their right side with their lower legs and heels positioned directly against the mattress. Upon entering the room, there were no additional pillows and/or positioning devices in place on the bed, floor, or in the room. The Resident did not have heel suspension/protection devices in place nor were there any observed in the room. An interview was completed with Licensed Practical Nurse (LPN) G on 10/30/24 at 7:34 AM. When queried regarding Resident #60's wounds and treatments, LPN G reviewed the Resident's EMR and stated the only treatment they had for the Resident was skin prep to heels. When queried regarding the wound on the Resident's coccyx/buttocks, LPN G reviewed the Resident's EMR again and verbalized they were unaware of the area because the treatment is completed on the night shift. LPN G revealed the wound care treatment on the Resident's coccyx/buttocks was not due to be completed. At 7:36 AM on 10/30/24, Resident #60 was observed in their room. The Resident was laying on their back and slightly on their right side with their lower legs and heels positioned directly against the mattress. On 10/30/24 at 8:27 AM, Resident #60 was observed in their room in bed. The Resident was laying on their back and slightly on their right side with their lower legs and heels positioned directly against the mattress. An interview was completed with RN CC on 10/30/24 at 8:29 AM. When queried regarding observation of Resident #60 being in the same position, lack of positioning devices, and lack of heel boots (suspension/protection devices), RN CC revealed they would need to review the Resident's EMR. No further explanation was provided. Resident #76 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/28/24 at 12:19 PM, Resident #76 was observed laying on their back in bed in their room. Their legs and heels were positioned directly against the mattress and both of their feet were pressed against the footboard of the bed. The knee section of the bed was observed to be elevated positioning their feet lower than their knees. Resident #76 was taller than average height for a male and their bed did not have a length extension in place. The Resident's left hand was in a fist and their left arm was visibly edematous and positioned flaccidly by their side directly on the mattress. When queried, Resident #76 revealed they had a stroke which effected their left side and had minimal movement in their left arm and hand. When queried if they were able to turn and reposition themselves in bed, Resident #76 verbalized they could not. When queried if the staff assist them to turn and reposition them in bed, Resident #76 verbalized they do not. When queried regarding the care they receive, Resident #76 stated, This place is terrible. When asked why, Resident #76 replied, The aides have attitude. Resident #76 was asked how the aides have attitude and replied, They tell me it's not their job when ask for help. Resident #76 further revealed there are rarely staff present on the unit and it takes an hour or two for staff to answer their call light when they do need assistance. Resident #76 specified there are two Certified Nursing Assistants (CNA) who check on them, but the rest do not. When queried if they had any open areas and/or wounds, Resident #76 relayed they had something on their buttocks but did not think it was open. On 10/29/24 at 8:16 AM and 10:57 AM, Resident#76 was observed laying in bed positioned directly on their back with their legs and heels positioned directly against the mattress. The knee area of the Resident's bed remained bent, and their feet lower than their knees and pressed against the footboard. Record review revealed Resident #76 was admitted to the facility on [DATE] with diagnoses which included left sided hemiplegia and hemiparalysis (one sided paralysis) following cerebral infarct (stroke), heart failure, diabetes mellitus, and weakness. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required maximum/substantial assistance for rolling/turning, bathing, and hygiene and total assistance for transferring. The MDS further revealed the Resident was at risk for, but did not have any pressure ulcers. Review of Resident #76's EMR revealed a care plan entitled, I have impaired skin integrity related to admission with shearing of the sacrum area (Initiated and Revised: 9/6/24). The care plan included the interventions: - Float my heels while in bed (Initiated: 6/22/24) - Turn and reposition q2h (Initiated: 6/22/24) - Weekly skin assessments (Initiated: 6/22/24) - Weekly wound measurement and evaluation (Initiated: 6/22/24) A second care plan entitled, I am at risk for altered skin integrity related to decreased mobility (Initiated: 9/6/24) was noted in Resident #76's EMR. The care plan included the intervention, Apply house stock barrier cream to skin prn to protect from moisture (Initiated: 9/6/24). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/30/24 at 5:10 AM, 8:35 AM, and 10:14 AM, Resident #76 was observed in their room in bed. The Resident was positioned on their back with their legs and heels positioned directly against the mattress. The knee area of the bed remained elevated causing the Resident's feet to be lower than then their knees. There were no additional pillows for positioning on the Resident's bed. An interview was completed with CNA C on 10/30/24 at 10:36 AM. When queried, CNA C confirmed they were assigned to care for Resident #76. CNA C was then asked if Resident #76 is able to turn and reposition themselves in bed and revealed they could not. When queried if the Resident was supposed to be turned and repositioned by staff, CNA C replied, Yeah. CNA C was asked when Resident #76 had last been turned and repositioned, CNA C stated, Well, I ain't done (Resident #76) yet this morning. It was last night. When asked what time, CNA C was unable to recall. When queried what time they started work, CNA C replied that they were doing a double. When asked what they meant, CNA C stated they worked days yesterday then came back for night (shift) and were now working day shift. When asked how they reposition Resident #76, CNA C replied, Turn and put a pillow under (Resident #76) if they ask for it otherwise (Resident #76) just lay on their back and raises the head of the bed. When asked if they were saying they only repositioned and offloaded pressure with a pillow if Resident #76 asked, CNA C confirmed and reiterated Resident #76 is able to raise the head of their bed with the bed controls. An observation of care and Resident #76's skin was completed with CNA C and Registered Nurse (RN) CC on 10/30/24 at 10:39 AM. On the ball area of Resident #76's left foot, under the great toe, a darkened and discolored area of skin, circular in shape and approximately the size of a nickel was noted. When asked if the area was blanchable, RN CC pressed on the area and blanching was not observed. When asked, RN CC confirmed the tissue was non-blanching. On Resident #76's distal left heel, a dark black colored area of tissue was observed. The area was circular, slightly smaller than a dime, and located directly over a bony prominence. RN CC was asked if the area was blanchable and applied pressure. The area directly over the darkened black area was observed to be non-blanchable. When queried, RN CC confirmed the area was non-blanchable. When queried, Resident #76 stated their left heel had been hurting. A follow up interview was completed with RN CC and Unit Manager Licensed Practical Nurse (LPN) P on 10/30/24 11:07 AM. When queried regarding observations of the Resident on their back in bed with their lower extremities positioned directly against the mattress and feet pressed against the foot board of the bed as well as staff statement related to repositioning, both RN CC and LPN P confirmed Resident #76 should be turned and repositioned every 2 hours. When queried regarding observations of Resident #76's heels not being elevated and/or floated in bed as indicted on their care plan, RN CC and LPN PP verbalized understanding but did not provide further explanation. When asked if the Resident had heel boots in place due to their lack of mobility and pressure ulcer risk, RN CC and LPN P revealed they did not. When queried if the area identified on the ball area of Resident #76's left foot under the great toe may have been caused from where the Resident's foot was pressing against the footboard, both staff revealed that may be the cause. When queried if the area was a pressure injury, RN CC affirmed it was. When queried if the area identified on the Resident's heel was also caused from pressure, the staff indicated it was. RN CC and LPN C were then asked what the areas would be classified as and revealed a Deep Tissue Injury (DTI- pressure ulcer with unknown depth due to intact skin and underlying tissue damage) or a suspected Deep Tissue Injury (sDTI- localized area of discolored intact skin with underlying tissue damage of unknown depth caused by pressure). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/30/24 at 11:30 AM, an interview was completed with the facility Administrator. When queried, the Administrator verified the Resident was unable to turn/reposition themselves and that their heels were supposed to be elevated off the mattress. The Administrator revealed they were surprised the Resident did not have heel boots in place. An observation of Resident #76 and their room was completed with the facility Administrator at this time. The Resident was observed lying in bed, positioned on their back upon entering the room. When queried regarding Resident #76's feet being pressed against the footboard of their bed, the Administrator confirmed Resident #76 is tall and the bed is short for them. When queried regarding the knee section of Resident #76's bed being elevated, causing their feet to be lower than their knees and the controller not working, the Administrator asked Resident #76 what happened, and the Resident confirmed the bed was stuck. The Administrator verbalized they would get a longer and functioning bed for them. The Administrator asked Resident #76 if they had heel boots in their room and Resident #76 informed them that they did not. On 10/31/24 at 12:03 PM, Resident #76 was observed laying in in bed on their back with their legs and heels positioned directly against the mattress. An interview was completed with RN HH on 10/30/24 at 2:00 PM. RN HH indicated wound images were obtained of Resident #76's feet and verbalized they did not see the areas identified with RN CC. A review of the images obtained by the facility revealed the areas identified were not included. A second skin observation of Resident #76's left foot was completed on 10/31/24 at 11:00 AM with RN CC. The darkened and discolored areas were present the Resident's left heel and the ball area under great toe. The ball area under the great toe was less pronounced. When queried, RN CC confirmed the areas remained but indicated the area on the ball area of the great toe had improved. When asked, RN CC applied pressure to the ball area under the great toe and blanching was noted. The area on the left heel remained discolored, dark and non-blanchable. When queried, RN CC confirmed the heel area was present. When asked, RN CC stated, Could be a sDTI and indicated it may have been caught early enough to prevent worsening. 22927 Resident #5: Observation on 10/28/24 at 12:00 PM of Resident #5 was seated up in a Broda style wheelchair in the resident's room. The state surveyor observed a dressing to left heel/foot while seated up in wheelchair. An interview on 10/28/24 at 12:14 PM with Resident #5 revealed that she did have wounds to her legs feet and went to the wound clinic for treatment. Resident #5 stated that she also had a wound to her tail bone that started about 2 weeks ago. In an interview on 10/30/24 at 02:00 PM, Licensed Practical Nurse (LPN) M the unit manager and wound care nurse revealed that Resident #5's Coccyx wound started on 10/24/2024 and that she wrote a progress note. Resident #5's coccyx pressure injury was facility-acquired. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 10/30/24 at 2:13 PM, Registered Nurse (RN) F stated that Resident #5's coccyx wound was worse than the picture taken on 10/25/2024. RN F stated that Resident #5 had just returned from the wound clinic with new orders. Record review of wound clinic orders dated 10/30/2024 revealed a Stage II Pressure injury to the Sacrum with ordered treatment of Santyl to wound bed, cover with border dressing, skin prep, change dressing daily & PRN if soiled/saturated. Clean with wound cleanser each dressing change. An interview on 10/31/24 at 08:07 AM with Resident #5 revealed her tailbone wound was getting bigger, and she feels it, it hurts to get up and sit the chair. The sore hurts and its uncomfortable. Blood sugar was 159 this morning. I'm a brittle diabetic. The meals don't come at the same time daily, and I don't get my insulin before my meals, the international diabetes center told me that I needed insulin prior to my meals and that does not happen a lot of time. Observation and interview was conducted on 10/31/24 at 11:11 AM with Registered Nurse (RN) T and Certified Nurse Assistant (CNA) C of Resident #5's sacrum/coccyx wound dressing change. Observation of resident's old sacrum/coccyx dressing was not dated. RN T applied Derma cleanse spray applied to wound and wiped with gauze. Wound measurements obtained by nurse: coccyx 8cm length x 1.5cm width, no depth measurement taken, palpation of wound edges noted left side tenderness of outside of wound. Resident #5 rated pain at 8 on the pain scale when area is touched, and a 3 on pain scale when not touched. Santyl applied with tongue depressor stick, 4 x 4 gauze applied and covered with foam border dressing, tape applied to edge of dressing to occlude edges. new brief placed. 38471 Resident #58: During initial tour on 10/28/2024, Resident #58 was observed resting in bed laying on her back, with only a pillow under her head. Resident #58 was asked if she had any open wounds on her body and she shared she has a sore on her bottom. On 10/28/2024 at approximately 7:30 AM, a review was completed of Resident #58's medical record and it revealed she initially admitted to the facility on [DATE] with diagnoses that included, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Pressure Ulcer of Sacral region, muscle wasting and atrophy and Acute Kidney Failure. Further review of Resident #58's records yielded the following: Progress Notes: 7/17/2024 at 15:17: When doing a skin assessment on this resident it was noted she has a new pressure wound to her coccyx .ordered an air mattress for the resident . 7/18/2024 at 12:38: .Wound #1 is an unstageable pressure to her coccyx . 8/7/2024 at 10:09: Assessed residents coccyx wound today, wound is draining purulent drainage. Wound bed 25% slough . 8/15/2024 at 12:42: Resident sent to the hospital . for further evaluation due to pressure on the coccyx and risk for infection . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Care Plan: (Resident #58) has actual impairment to skin integrity r/t (related to) abrasions Stage 2 right buttocks .If the resident refuses treatment, confer with the resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods .The resident needs assistance to turn/reposition at least every 2 hours, more often as needed as she will allow .I have impaired cognitive function or impaired thought processes r/t mild cognitive impairment .Bed mobility: 1 require extensive assist of 1. Dressing: I require extensive assist of 1 .Transfers: mechanical lift 2PA (person assist) . July 2024 TAR (Treatment Administration Record): Review was completed of the TAR, and it indicated on 7/2/2024, 7/9/2024 and 7/16/2024 (one day before the pressure injury was discovered) a body audit was documented as completed on Resident #58, that stated no new skin breakdown. On 7/17/2024 an unstageable pressure injury to Resident #58's coccyx was discovered. August 2024 TAR: Resident #58 did not receive scheduled wound treatments on the following days: 8/10/24 8/13/24 8/23/24 8/24/24 8/26/24 Furthermore, Resident #58 was sent to the hospital on 8/15/2024, but nursing staff did not indicate that on the TAR so it appeared the resident missed multiple wound treatments. Cleanse coccyx wound with wound cleanser, pat dry apply calcium alginate with silver, cover foam dressing, change daily and prn. Started on 7/25/2024 and discontinued on 8/19/2024. Cleanse coccyx wound with wound cleanser, pat dry apply calcium alginate with silver, cover foam dressing, change daily and prn. Started and discontinued on 8/23/2024. Resident #58 never received this treatment to her wound. September TAR 2024: Resident #58 did not receive scheduled wound treatments on 9/8/2024, 9/17/2024 and 9/25/2024. October TAR 2024: Resident #58 did not receive scheduled wound treatments on 10/2/24 and 10/7/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/30/2024 at 2:10 PM, an interview was conducted with Unit Manager/Wound Care Nurse M regarding Resident #58's facility acquired coccyx wound. Nurse M expressed the resident will not turn and reposition and prior to development of the wound she refused the specialty mattress. Nurse M was queried on what the facility has trialed to offload the resident from her back. When asked about a wedge pillow or body pillow or other unique way to offload her. Nurse M reported they had not tried anything of that nature to her knowledge. Nurse M was asked when the last time the resident has been out of bed, and she reported it had been a while. Nurse M expressed once she was alerted to the wound it was already progressing and its highly unlikely the wound was not present the day prior when the body audit was completed. Nurse M explained given the presentation of the wound there would have been the presence of skin impairment in this area prior to facility staff alerting her to the wound. The wound developed due to the resident positioning in bed. Nurse M was asked to provide any evidence that showed facility staff were attempting other methods to offload the resident and/or get her out of bed since wound inception. On 10/29/2024 at approximately 8:00 AM, Resident #58 was observed laying in bed on her back. Further review was conducted of Resident #58's wound documentation from inception on 7/17/2024: 7/17/2024: 0.87 cm (centimeter) x 2.13 x 0.52cm: Unstageable pressure, 100% slough, periwound is non-attached. 7/24/2024: 1 cm x 1.92cm x 0.76cm; Unstageable pressure, 100% slough, moderate serous exudate . 7/31/2024: 1.21cm x 1.91xm x 0.78; Unstageable pressure, 100% slough, non- attached edges, progress -deteriorating . 8/7/2024: 8.84cm x 4.36cm x 2.94cm; Unstageable pressure, 30 [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed provide care and services prevent urinary tract infections for 5 residents (#5, #11, #40, #81, #83), resulting in the potential for recurrent urinary tract infections, and cross contamination with the potential for prolonged illness, antibiotic therapy and/or hospitalization s. Findings include: Record review of facility 'Catheter Care, Urinary' policy dated 5/2024 revealed the purpose of the procedure was to prevent catheter-associated urinary tract infections. Resident #5: In an interview on 10/28/24 at 12:20 PM with Resident #5 revealed that her urinary Suprapubic catheter did not get changed as it should. The resident has to tell staff to change the catheter. Resident #5 stated that the catheter is to be changed monthly and that it is supposed to come up on the computer, but it doesn't get changed. It didn't get changed as it should and that she worries about getting infections. Resident #5 stated that her suprapubic catheter care does not get done regularly. Record review of Resident #5's Kardex care guide dated 10/28/2024 revealed Certified Nurse Assistant to provide catheter care each shift and as needed, record urine output each shift. Record review of Resident #5's Catheter care/output/kink each shift (3 times daily) checks task form 30 day look back revealed catheter care was given: No documented catheter care or output on: October 6th, 7th, 8th, 10th, 12th, 13th, 15th, 17th, 18th, 19th and 23rd. Catheter care given one time a day: 2nd, 3rd, 11th, 16th, 20th, 21st, 22nd, 24th and 30th. Catheter care two times daily: 1st, 4th, 27th, and 29th. Catheter care given 3 times daily: 9th, 14th, 25th, 26, and 28th. Record review of Resident #5's care plans pages 1-46 revealed Resident #5 was at risk for Multidrug Resistant Organism related to suprapubic catheter and wounds. Interventions dated 11/9/2023 included: Educate on hand hygiene, enhanced barrier precautions. Record review of Resident #5's Activity of Daily Living (ADL) care plan revision dated 10/18/2023 revealed that Resident #5 had self-care deficit related to weakness, unsteady gait, pain and diagnosis of multiple sclerosis. Interventions included: two persons assist with bathing, mechanical transfers, dressing, bed mobility and toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2024 revealed order on 2/29/2024 to replace old catheter with new catheter 24 French every 30 days. Record review of the catheter change order dated 5/29/2024 was blank. Record review of Resident #5's nursing progress notes dated 5/29/2024 revealed there was no note for resident refusal or nurse note of why the catheter was not changed. Record review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June 2024 revealed order on 2/29/2024 to replace old catheter with new catheter 24 French every 30 days. Record review of the catheter change order dated 6/29/2024 was blank. Record review of Resident #5's nursing progress notes dated 6/29/2024 revealed there was no note for resident refusal or nurse note of why the catheter was not changed. Record review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for July 2024 revealed order on 2/29/2024 to replace old catheter with new catheter 24 French every 30 days. Record review of the catheter change order dated 7/29/2024 was blank. Record review of Resident #5's nursing progress notes dated 7/29/2024 revealed there was no note for resident refusal or nurse note of why the catheter was not changed. Record review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2024 revealed order on 2/29/2024 to replace old catheter with new catheter 24 French every 30 days. Record review of the catheter change order dated 8/29/2024 was documented as changed. Record review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for September 2024 revealed order on 2/29/2024 to replace old catheter with new catheter 24 French every 30 days. Record review of the catheter change order dated 9/12/2024 was changed. Record review of Resident #5's nursing progress notes dated 9/12/2024 revealed there was no note for resident refusal or nurse note of why the catheter was not changed. Record review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for October 2024 revealed order on 10/10/2024 to replace old catheter with new catheter 24 French every 30 days. Record review of the catheter change order dated 10/10/2024 was blank. Record review of Resident #5's nursing progress notes dated 10/10/2024 revealed there was no note for resident refusal or nurse note of why the catheter was not changed. Record review of Resident #5's catheter care task 30-day lookback dated 10/1/2024 through 10/30/2024 revealed that inconsistent catheter care was provided sporadically. The 30-day lookback revealed that there were days when no catheter care was documented by certified nurse assistants. Observation on 10/31/24 at 11:11 AM with Registered Nurse (RN) T and Certified Nurse Assistant (CNA) C of Resident #5's observed the suprapubic catheter site with no dressing in place to suprapubic catheter site, secure device noted to right thigh. Resident #40: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/28/24 at 09:48 AM with Resident #40 revealed that the facility nurses were not changing the suprapubic urinary catheter as ordered by the physician. Resident #40 stated that she went to the hospital with an infection, and it hurt at the suprapubic catheter opening. Resident #40 stated that she had to ask to go to the hospital. The state surveyor Observed a catheter bag hanging at the bedside. Resident #40 stated that they don't clean it, and they don't change the catheter every month like is supposed to. Resident #40 stated that she went to the hospital and the hospital changed her catheter. Record review of Resident #40's August Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated August 2024 revealed to change suprapubic catheter as needed or if unable to flush or becomes dislodged, signs and symptoms of infection. No change was documented. Record review of Resident #40's September Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated September 2024 revealed to change suprapubic catheter as needed or if unable to flush or becomes dislodged, signs and symptoms of infection. No change was documented. Record review of Resident #40's progress note dated 9/10/2024 at 2:15 PM noted suprapubic site is red, swollen and had thick white drainage noted around the site. The drainage had a foul odor . Record review of Resident #40's progress note dated 10/24/2024 at 3:31 PM noted suprapubic site is excoriated/denuded skin . Progress note dated 10/25/2024 at 3:52 AM resident requested to be sent to the emergency room . Record review of Resident #40's progress note dated 10/25/2024 at 10:39 AM resident returned from hospital with antibiotic Bactrim DS twice daily for 10 days for urinary tract infection. Observation on 10/31/24 at 09:52 AM with Certified Nurse Assistant (CNA) C of Resident #40's observation of suprapubic site, noted with urinary catheter opening to be within a skin fold noted a white small ball of material noted to site. Resident #40 stated that they just cleaned it last night. Resident #83: Observation on 10/28/24 at 10:57 AM resident #83 was lying in bed in lowest position with urinary catheter bag and tubing laying on the floor. The state surveyor went back out into the hallway to get Registered Nurse (RN) P. Observation and interview on 10/28/24 at 10:59 AM with Registered Nurse (RN) P came into Resident #83's room. RN P stated that Resident #83 has had frequent falls, and we moved her to this hall for carpet floor and high visual hallway. Observation on Resident #83's catheter bag on the floor and the tubing laying on the floor. Observation on 10/31/24 at 08:31 AM of Resident #83 was Observed lying in bed in low position with urinary catheter bag on the floor. Catheter bag has one sided blue leaf cover that is not under the catheter bag while on the floor. Record review of Resident #83's electronic medical record progress notes documented admitted [DATE] and on 9/10/24 family requested Resident #83 be sent back to the hospital. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #83's electronic medical record revealed on 9/13/2024 Resident #83 hospital discharge summary revealed resident was sent to hospital form nursing home due to urinary tract infection. Discharge diagnosis complicated urinary tract infection. 37668 Resident #11: On 10/28/24 at 11:45 AM, Resident #11 was observed sitting in a wheelchair in their room. An indwelling urinary catheter drainage bag was in place under the wheelchair. The urinary drainage bag and tubing were both directly touching the floor. When queried regarding their urinary catheter, Resident #11 stated, I've had a lot of UTI's and yeast infections since being at the facility. Resident #11 continued, They don't want to give me anything for the yeast infections. When queried how often staff provide catheter care, Resident #11 revealed they do not receive timely care because the facility is short staffed and the staff don't care. Record review revealed Resident #11 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included left leg fracture, diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD), depression, urinary retention, and Urinary Tract Infections (UTI's). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required substantial to total assistance to complete all Activities of Daily Living (ADL) with the exception of eating. The MDS further detailed the Resident had an indwelling urinary catheter. On 10/30/24 at 5:17 AM, Resident #11 was observed in bed. The Resident was positioned on their back and their eyes were closed. The indwelling urinary catheter drainage bag was laying directly on the floor. The drainage bag was not hooked to the bed. At 8:20 AM on 10/30/24, Resident #11 was observed laying on their back in bed. The indwelling urinary catheter drainage bag remained in the same position, directly on the floor, and not hooked to the bed. Review of Resident #11's Electronic Medical Record (EMR) revealed a care plan entitled, have altered urinary status indwelling catheter (Initiated: 5/7/24; Revised: 8/23/24). The care plan included the intervention - Catheter care every shift and PRN (as needed) (Initiated: 8/23/24) - Ensure tubing is secured (Initiated: 8/23/24) Resident #81: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 10:03 AM, Resident #81 was observed lying in bed with their eyes closed. The Resident's indwelling urinary catheter drainage bag was laying directly on the floor next to the bed. Resident #81's family members, Witness II and Witness JJ were present in the room. When queried regarding the catheter drainage bag being positioned directly on the floor, both Witness II and Witness JJ verbalized the indwelling urinary catheter drainage bag is always directly on the floor when they visit. When queried how often they visit, Witness II and Witness JJ revealed they visit six days a week. Record review revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, dementia, depression, heart disease, Benign Prostatic Hyperplasia (BPH- enlarged prostate) urinary retention, and left leg below the knee amputation. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required partial to total assistance to complete all ADL's with the exception of eating. The MDS further revealed the Resident had an indwelling urinary catheter. On 10/30/24 at 5:10 AM and 10:16 AM, Resident #81 was observed laying in bed with their eyes closed. Their indwelling urinary catheter drainage bag was directly on the floor and not hooked on the bed. On 10/31/24 at 11:09 AM, Resident #81 was observed lying in bed on their back. Their Resident's indwelling urinary catheter drainage bag was directly on the floor and not hooked on the bed. On 10/31/24 at 11:45, Resident #81 remained in the same position in bed on their back with their indwelling urinary catheter drainage bag positioned directly on the floor and not hooked to the bed. At 11:49 AM on 10/31/24, Unit Manager Registered Nurse (RN) CC was asked to go into Resident #81's room. When queried regarding the Resident's indwelling urinary catheter drainage bag, RN CC verbalized the drainage bag should not be laying on the floor.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22927 Based on interview and record review, the facility failed to obtain weights timely for 2 Residents (#9, #80), resulting in unassessed weight loss with the potential of unmet care needs. Findings include: Resident #9: In an interview on 10/28/24 at 10:27 AM with Resident #9 in his room revealed that he had lost weight and that he did not know why. Resident #9 stated that he did have a peg tube that that staff used for his formula stuff feed. Record review of Resident #9's weight log revealed weight on 10/2/24 of 147.2 pounds, and on 10/18/24 a weight of 130.1 pounds. That was a 17.1-pound loss in 16 days. Weight loss percentage of 11.62% loss. Record review of Resident #9's care plans pages 1-34 revealed care plan revision date of 8/28/2024 for malnutrition related to dysphagia with latest intervention dated 9/27/2024 of supplements as ordered: 30ml Critical Care Pro-heal TID (three times daily) via peg tube. Resident #80: Observation on 10/28/24 during the initial tour of the facility revealed Resident #80 was lying in bed and thin in appearance. The Resident #80 made eye contact but did not say anything at that time. Observation of Peractive tube feeding solution was infusing at 60cc/hr. Observation on 10/29/24 at 08:12 AM with Registered Nurse (RN) F during medication pass revealed that Resident # 80's peg tube pump was beeping alerted nurse and state surveyor in hallway. Observation of Resident #80's room revealed an empty bottle hanging at bed side dated 10/28/24 at 12:00 PM noon. The tube feeding bottle was empty and new bottle is set on overbed table not labeled. RN F stated that the night shift just leaves the full bottle at the bedside and do not hang it. To do the math 1000cc bottle to run at 60cc/hr., dated 10/28/2024 at 12:00 PM should have run 16 hours and new bottle hung at 4 AM, but was let run until 8:12 AM. Record review of Resident #80's October Medication Administration Record (MAR) revealed on enteral feeding order at bedtime related to dysphagia. Peractive 60ml/hr. with 40ml water flush continuous. Hang tube feeding at 10:00 PM. Started on 9/26/2024. Record review of Resident #80's care plans page 1-23 revealed that on 9/20/24 revision of significant weight loss with hospitalization with interventions updated in June 2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 10/29/24 at 03:17 PM with the Corporate Registered Dietitian AA revealed that residents' re-weights should be done when requested. The Registered Dietitians review the resident weights and then request a re-weight. The Corporate Registered Dietitian AA revealed that she looks at trends. Resident #80 has fluid issues month to Month. The re-weight policy is in the weight policy. There was no need to re-weigh the residents. The Corporate Registered Dietitian AA revealed that Diabetics should get their insulin consistently, based on when they eat, we give insulin to what the order states. Record review of the facility 'Weight' policy dated 4/2023 revealed the purpose of weight changes have a significant nutritional implication. The purpose of this policy is to help maintain acceptable parameters of nutritional status. (2.) Nursing staff weighs and records resident weights each month by the 10th of the month. Weekly weights are obtained on those residents within the first 4 weeks of admission and those residents deemed appropriate per the assessment of the dietitian, dietary manager, physician or as determined by IDT. Any refusals will be documented in the chart. (3.) Weights and re-weight results with dates obtained are recorded in resident chart.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 22927 Based on observation, interview and record review, the facility failed to ensure accuracy of enteral feeding orders for one resident (#80), resulting in Resident #80's enteral feeding material order to be incomplete, with the potential for enteral tube malfunction/weight loss. Findings include: Resident #80: Observation on 10/28/24 during the initial tour of the facility revealed Resident #80 was lying in bed and thin in appearance. The Resident #80 made eye contact but did not say anything at that time. Observation of Peractive tube feeding solution was infusing at 60cc/hr. Observation on 10/29/24 at 08:12 AM with Registered Nurse (RN) F during medication pass revealed that Resident # 80's peg tube pump was beeping alerted nurse and state surveyor in hallway. Observation of Resident #80's room revealed an empty bottle hanging at bed side dated 10/28/24 at 12:00 PM noon. The tube feeding bottle was empty and new bottle is set on overbed table not labeled. RN F stated that the night shift just leaves the full bottle at the bedside and do not hang it. To do the math 1000cc bottle to run at 60cc/hr., dated 10/28/2024 at 12:00 PM should have run 16 hours and new bottle hung at 4 AM, but was let run until 8:12 AM. Record review of Resident #80's October Medication Administration Record (MAR) revealed on enteral feeding order at bedtime related to dysphagia. Peractive 60ml/hr. with 40ml water flush continuous. Hang tube feeding at 10:00 PM. Started on 9/26/2024. In an interview and record review 10/30/24 at 10:13 PM with Corporate Clinical Specialist A acting as the Director of Nursing (DON), discussion of Resident #80's Tube feeding on 10/27/2024 was to be hung at 10:00 PM on 10/28/2024 but was hung at on 10/28/2024 at 12:00 PM (noon) and not replaced until 8:40 AM we calculated the amount. Corporate Clinical Specialist A stated that the order was incorrect in the electronic medical record, and that the order only had one time for the nurse to document on it needs to have a put-up time (hang time) and take-down time, which we reviewed it after speaking with you, and we have corrected the order. Registered Nurse F wrote the order wrong, and he had no take-down time for documentation. The Physician orders need to be followed. Record review of the facility 'Enteral Nutrition' policy dated 1/2024 revealed adequate nutritional support through enteral nutrition is provided to residents as ordered. (4.) Enteral nutrition is ordered by the provider based on the recommendations of the dietitian.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview and record review, the facility failed to implement a procedure for effective communication and coordination of care with dialysis for one resident (Resident #41) of one resident reviewed, resulting in a lack of communication regarding vaccine administration, Resident #41 receiving duplication vaccinations, and the potential for side effects, ongoing lack of communication, and duplicate medication therapy. Findings include: Resident #41: Record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses which included dementia, legal blindness, arthritis, falls, diabetes mellitus, and end stage renal disease with dialysis dependence. Review of the Minimal Data Set (MDS) dated [DATE] revealed the Resident was severely cognitively impaired and required maximum to total assistance to complete Activities of Daily Living (ADL). Review of Resident #41's Electronic Medical Record (EMR) revealed the Resident received dialysis two times a week. Resident #41 had a care plan in place entitled, I need hemodialysis . facility will arrange transportation. Monday and Friday at 12:15 PM to 4:30 PM . (Initiated: 8/2124; Revised: 8/26/24). There were no dialysis communication forms present in Resident #41's EMR. On 10/30/24 at 10:18 AM, a three-ring binder labeled (Resident #41) dialysis was observed at the nurses' desk. The three-ring binder contained blank dialysis communication forms. An interview was conducted with Transportation Certified Nursing Assistant (CNA) BB and Registered Nurse (RN) CC. When queried regarding the facility procedure related to communication with dialysis facilities, CNA BB revealed the nursing staff at the facility send a form with the Resident and the dialysis staff complete a portion of the form and send it back with the Resident. When queried where the forms are kept after they are completed and returned to the facility with the resident, CNA BB indicated they are placed in the resident's three-ring binder. When queried why Resident #41's three-ring binder only contained blank forms, CNA BB stated, They (administration) took all the forms. The forms were requested from RN CC at this time. A review of Resident #41's Hemodialysis Communication Forms on 10/31/24 at 11:00 AM revealed the following: - Form dated 9/9/24: The section of the form, Completed by Nurse at Dialysis Unit was blank. - Form dated 10/7/24: The section of the form, Completed by Nurse at Dialysis Unit detailed the Resident received Flu Vaccine Flublok Trivalent as a Medications given during the dialysis treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #41's Immunization documentation and Medication Administration Record (MAR) in the EMR revealed the Resident received the Influenza Vaccine on 10/2/24 at the facility. An interview was completed with Infection Control Unit Manager RN P on 10/31/24 at 12:11 PM. When queried if Resident #41 received the Influenza Vaccination at the facility on 10/2/24, RN P confirmed they did. RN P was then shown Resident #41's Hemodialysis Communication Form dated 10/7/24 and queried regarding the form indicating Resident #41 received the Influenza Vaccine during dialysis. RN P reviewed the documentation and confirmed a second Influenza vaccine was administered to the Resident while they were at dialysis. When queried regarding the facility policy/procedure related to communication of immunization administration, RN P revealed they were unaware of a specific policy. When asked if the vaccination administered at the facility was entered into MCIR (Michigan Care Improvement Registry- an immunization database) on 10/2/24, RN P reviewed Resident #41's MCIR and stated, Not on MCIR. With further inquiry, RN P verbalized the immunization was not entered by the facility or the dialysis center. RN P was then queried regarding facility policy/procedure related to entering vaccination administration into MCIR and replied, I started entering them (Influenza Vaccines) in MCIR the weekend after the big push (of vaccination administration to residents) but then I've been working the floor. RN P revealed they did not have time to finish entering all the residents who had received the vaccination because they had to work the floor due to lack of staff. An interview was conducted with the facility Administrator on 10/31/24 at 2:18 PM. When queried regarding Resident #41 receiving duplicate vaccinations and lack of communication and coordination of care with dialysis facility, the Administrator verbalized Resident #41 should not have received duplicate vaccinations, and the concern would be addressed. Review of facility provided policy/procedure entitled, Influenza Vaccine Resident and Staff did not address coordination of care with dialysis treatment center.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to complete or respond timely to medication regimen reviews for three residents (R19, R42, R67) of five residents reviewed for medication regimen reviews, resulting in missed months for medication review and medication reviews not responded to for eight months. Findings include: Resident #19 (R19): R19 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cerebral palsy, dysphagia, anxiety disorder and need for assistance with personal care. R19 has a BIMS (brief interview for mental status) score of 13, indicating they are cognitively intact. R19 has a guardian due to the inability to make their own medical decisions. On 10/30/24 at 02:42 PM, record review of the EMR (electronic medical record) for R19 revealed that a MRR (medication regimen review) was not completed in July of 2024. Resident #42 (R42): R42 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include borderline personality disorder, anxiety disorder, major depressive disorder and dementia. R42 has a BIMS of 9, indicating moderate cognitive impairment. On 10/30/24 at 08:54 AM, record review of the EMR for R42 revealed a missing MRR for July 2024. On 10/30/24 at 08:57 AM, record review of an MRR for 03/12/24, revealed that a GDR (gradual dose reduction) should be attempted for R42 related to antipsychotic medication use. The form was not signed until 5/31/24, over two months after the recommendation was made. 38471 Resident #67: During initial tour on 10/28/2024 Resident #67 was observed resting in recliner as his wife was visiting. On 10/28/2024 at approximately 2:30 PM, a review was conducted of Resident #67's medical record and it indicated he admitted to the facility on [DATE] with diagnoses that included Dementia, Atrial Fibrillation, Diabetes, Adjustment Disorder with mixed anxiety and Alzheimer's Disease. Further review of Resident #67's chat yielded the following: Care Plan: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	I use psychotropic medications r/t (related to) adjustment disorder with mixed anxiety and depressed mood, vascular dementia with psychotic disturbance . Consult with pharmacy, MD to consider dosage reduction when clinically appropriate . On 10/30/2024 at 1:45 PM, a review was completed of Resident #67's MRR (Medication Regime Reviews) from December 2023- October 2024. It was found the pharmacist preformed the reviews and had two recommendation that indicated see pharmacy report. The facility complies the MRR into binders upon completion and then the physician will respond to them. 2/5/2024 12:13: Monthly MRR Performed- See Pharmacy report .The resident has been taking Alprazolam 0.25 mg every 12 hours since 6/29/23 without a GDR (gradual dose reduction). Could we attempt a dose reduction at this time to perhaps 0.25 mg QD to verify this resident is on the lowest possible dose? If not indicate response below. 4/9/2024 12:21: Monthly MRR Performed- See Pharmacy report .This resident has been taking Mirtazapine 15 mg QD since 12/23 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below. Both of Resident #67's MRR were not responded to by the physician until the facility was questioned regarding the medication recommendations. On 10/30/2024 at 4:50 PM, the Administrator reported the physician did not address Resident #67's medication regime reviews from 2/2024 and 4/2024. 10/31/24 02:18 PM, the Administrator reported there were no timeframes for response to pharmacy recommendations. Review was completed of the facility policy entitled, Medication Regime Review, dated 08/2020. The policy stated, The consultant pharmacist performs a comprehensive review of each resident's medications regimen and clinical record at least monthly. The medication regime review (MRR) includes evaluating the resident's response to medication therapy to determine the the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences to medication therapy The findings are phoned, faxed, or e-mailed within 24 hours or in accordance with facility policy .Recommendations are acted upon and documented by the facility staff and/or prescriber. The prescriber accepts and acts upon recommendations or rejects provides an explanation for disagreeing . The facility was unable to provide a policy that indicated appropriate time frames for the different steps in the MRR process.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to ensure that three residents (#75, #80 and #82) of 5 residents reviewed for unnecessary medications had adequate indications for usage, care plan implementation and appropriate monitoring, resulting in the increased potential for serious adverse side effects and adverse reactions, and the inability to monitor the effectiveness of antipsychotic and hypnotic medication treatment due to lack of documented supporting evidence. Findings Include: Resident #75: During initial tour on 10/28/2024, Resident #75 was observed in the common area with other residents and staff. On 10/28/2024, at approximately 1:25 PM, a review was conducted of Resident #75's medical record and it indicated he admitted to the facility on [DATE] with diagnoses that included Cerebral Palsy, Acute Respiratory Failure, Dysphagia, Hypertension and Chronic Obstructive Pulmonary Disease. Further review yielded the following: Physician Orders: Medication Class: Hypnotic/Sedative/Sleep Disorders Agents Ramelteon Oral Tablet 8 MG-Give one tablet via PEG-Tube at bedtime for sleep. Zolpidem Tartrate Tablet 5 MG (milligram)- give one tablet via PEG- Tube at bedtime for difficult sleeping at bedtime. Ordered on 9/11/2024. It can be noted Resident #75 did not have a sleep disorder diagnosis. Care Plan: .[NAME] is on Hypnotic Therapy r/t related problems with sleep . Do not exceed recommended daily dose thresholds for hypnotic medications in the elderly unless stated by MD: Ramelteon 8 mg, Temazepam 15 mg, Zolpidem 5 mg .May cause day time drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness. Observe for possible side effects q-shift . On 10/29/2024 at 2:50 PM, Social Worker S was queried regarding Resident #75's indication for usage for Zolpidem. This writer and social worker searched the chart and were not able to identify an appropriate indication for hypnotic usage. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 11:05 AM, an interview was conducted with Social Worker S and Psychiatric Nurse Practitioner GG regarding Resident #75's Zolpidem. It was explained the resident was initially started on hypnotic medication when he was in the hospital, and they continued the medication upon his readmission to the facility. After a pharmacy recommendation they changed the medications from Ramelteon to Zolpidem. Social Worker S and Psychiatric Nurse Practitioner GG were not able provide substantial documentation that detailed why Resident #75 required the medication when he had no documented evidence of sleeping concerns or subsequent diagnosis. Resident #80: On 10/30/2024 at approximately 7:45 AM, a review was conducted of Resident #80's medical record and it indicated he readmitted to the facility on [DATE] with diagnoses that included, Hemiplegia, Acute Respiratory Failure, Pleural Effusion, Major Depression Disorder, Vascular Dementia and Insomnia. Physician Orders: Ramelteon Oral Tablet 8 MG- give one table via PEG-Tube at bedtime for insomnia- ordered on 5/9/2024. It can be noted Resident #80 did not have a care plan, monitoring or sleep tracking as it related to his hypnotic usage. On 10/30/2024 at 11:05 AM, an interview was conducted with Social Worker S and Psychiatric Nurse Practitioner GG regarding Resident #80's Ramelteon. It was explained the medication was initially started when he was admitted to the hospital in 4/2024 and continued upon his readmission to the facility. Social Worker S was asked if Resident #80 should have a care plan and monitoring for his usage of the hypnotic, the social worker reported he should. Resident #82: During initial tour on 10/28/2024, Resident #82 was observed sleeping in bed and did not appear to be in any distress. On 10/28/2024 at approximately 1:00 PM, a review was completed of Resident #82's medical record and it revealed he was admitted to the facility on [DATE] with diagnoses that included, Autistic Disorder, Dysphagia, Major Depression, Dementia and Anxiety. Further review of his chart yielded the following: Physician Orders: Historical view of Risperdal (antipsychotic medication) orders: Risperdal Oral Tablet 2 MG (milligram)- give one tablet by mouth two times a day for Antipsychotic/Antimanic agents. - ordered on 8/23/2024 and ended on 9/20/2024 Risperdal Oral Tablet 2 MG (milligram)- give one tablet by mouth two times a day related to Autistic Disorder - order updated on 9/20/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 2024 MAR (Medication Administration Record): Review was completed of the anxiety, depression and psychosis behavioral charting and there were no behaviors displayed throughout October for Resident #82. On 10/28/2024 at 2:10 PM, an interview was conducted with Psychiatric Nurse Practitioner GG regarding Resident #82's Risperdal indications for usage. It was explained the resident admitted to the facility on this medication and while he has uncertainty regarding the indication, its likely utilized for behavioral disturbance related to his autism diagnosis. On 10/29/2024 at 2:55 PM, Social Worker S' reported Resident #82 admitted to the facility on Risperdal. When asked why the resident had continued usage of the antipsychotic when no behaviors had been displayed (per facility charting) and what the indication for use was. Social Worker reported he would investigate this. Social Worker S provided a document form the FDA regarding Risperdal that stated, Indications for usage .1. 3 Irritability Associated with Autistic Disorder . It was explained Resident #82's indications for usage in his medical record was not appropriately categorized until the facility was questioned regarding it. Social Worker S expressed understanding. Review was completed of the facility policy entitled, Psychotropic Medication Use, revised July 2022. The policy stated, .Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record . Residents receiving psychotropic medications are monitored for adverse consequences .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 22927 Based on observation, interview and record review, the facility 1) Failed to prevent pre-set up medications to be found in 2 of 5 medication carts, 2) Failed to prime a new insulin pen prior to administration, and 3) Failed to provide insulin administration timely and per a physician's order for 1 resident (Resident #5), resulting in a medication error rate greater than 5%, and the potential for wrongful administration of pre-set up medications and unmanaged medical conditions requiring therapeutic drugs with the potential for complications and increased blood glucose levels. Findings include: Record review of the facility 'Medication Administration' policy dated 11/2023 revealed medications are administered in a safe and timely manner, and as prescribed. (7.) Medications are administered within one (1) hour of their prescribed time, unless otherwise specified Record review of the facility 'Insulin Administration' policy dated 1/2024 revealed characteristics and types of insulin noted three key characteristics of insulin are: Onset of action- (a.) how quickly the insulin reaches the bloodstream and begins to lower blood glucose. (b.) Peak effects- the time when the insulin is at its maximum effectiveness. (c.) Duration of effects the length of time during which the insulin id effective. Record review of facility 'Diabetes-Clinical Protocol' policy dated 4/2024 revealed as part of the initial assessment, the physician will help identify individuals with elevated blood sugar, impaired glucose tolerance, or confirmed diabetes, as well as factors that may influence glucose tolerance. Record review of insulin manufacturer insulin pen 'Instruction for use' instructions dated 9/11/2015 instructed to prime your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 5: To prime your pen, turn the dose knob to select 2 units. Step 6: Hold you pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 7: Continue holding pen with needle pointing up. Push the dose knob in until it stops and zero is seen in the dose window 1) Prevent pre-set up medications Observation and interview on 10/29/24 at 07:11 AM with Registered Nurse (RN) F during morning medication administration observation revealed in the Bay one-unit medication cart top drawer revealed pre-set up medications punched out of the package of metropole 2 tablets 25mg in a clear plastic cup unmarked medication cup and a white loose tablet in the top drawer. RN F stated that the medication was there when he took over the medication cart that morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/29/24 at 07:15 AM with Licensed Practical Nurse (LPN) B observation of the coast Medication room medication on fridge temp log was not consistently filled out/documented temp checks. On 10/29/24 at 07:20 AM with LPN B of the supply room between the Coast and Bay units revealed tube feeding supplies. LPN B retrieved an instant ice bag and walked back to Resident #50 room and applied to the residents left knee. LPN B walked back to the cart, and began medication pass with no hand hygiene. Observation 10/29/24 at 07:32 AM with LPN B did not do hand hygiene prior to medication administration after going to med room and supply room and back to the medication cart. Observation on 10/29/24 at 07:35 AM with LPN B of top drawer on Coast medication cart noted two clear plastic medication cups with crushed medications. LPN B stated the medications were for Resident # 21Fluoxetine, second cup with whole tablets of Coreg and clozapine in cups in top drawer there were no identification or resident name on the cups. 2) Failed to prime new insulin pen prior to administration Observation and interview on 10/29/24 at 07:55 AM with Licensed Practical Nurse (LPN) N on the secure dementia unit during medication pass. LPN N was at the medication cart looking for Resident #52's Humalog insulin. There was no pen found in the medication cart in the dementia unit. LPN N proceeded to the Coast/Harbor medication room fridge for a new insulin pen. Observation on 10/29/24 at 07:58 AM with LPN N opened the new insulin pen, attached a needle to the end of the pen and dialed up the medication dose. 0bservation of Resident #52's administration of insulin to the resident's abdomen. Observation of the of the new insulin pen, was not primed prior to injection. 3) failed to provide insulin administration timely Resident #5: Observation on 10/28/2024 at 10:30 AM of Registered Nurse/Infection Preventionist P was observed to draw up insulin and enter Resident #5's room. In an interview on 10/28/24 at 10:40 AM with Resident #5 stated that she just received her morning insulin which was to be given before breakfast just now at 10:30 AM. Resident #5 stated that her medications are late a lot of the time. Record review of Resident #5's October 2024 Medication Administration Record (MAR) for the date of 10/28/2024 revealed: Lispro insulin subcutaneous solution pen-injector 100 units/ml, inject 9 units subcutaneously three times a day related to type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema. Administration times: 8:00 AM, 12:00 PM and 5:00 PM. Record review of Resident #5's October 2024 Medication Administration Record (MAR) for the date of 10/28/2024 revealed: Lantus insulin subcutaneous solution pen-injector 100 units/ml, inject 14 units subcutaneously two times a day related to type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema. Administration times: 8:30 AM and 8:30 PM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's diabetes mellitus type 1 with diabetic neuropathy and polyneuropathy care plan revealed nursing interventions of accu-check and insulin as ordered, staff to administer dated 5/2/2023, may use resident's personal Dexcom blood glucose monitor for blood glucose monitoring dated 2/23/2024 were some of the interventions listed. In an interview on 10/29/24 at 02:59 PM with Registered Nurse/Infection Preventionist P RN/IP was working the Bay unit medication cart on 10/28/24. RN P was asked about Resident #5's Insulin administration was at 10:30 AM but supposed to be given at 8:00 AM. RN/IP P found out that she was working the medication cart at 6:20 AM from a text at home and had to come into work. RN/IP P usually worked at 8 AM. RN/IP P stated that she had just put in 12 days on call, here every day, so in the morning she did not think about checking the text messages. There are a lot of call-ins, RN/IP P was the only unit manager. Licensed Practical Nurse (LPN) M was working the floor only, but when the state people came in LPN M showed up as a manager. RN/IP P stated that she did pass medications late because she did not know the residents and the facility let her know last minute that she was working. RN/IP P would work the night shift to pick-up for staffing call-ins. The Director of Nursing (DON) does work, the corporate consultant is a nurse but does not pick-up floor hours and the Minimum Data Set (MDS) assessment nurse does not work the floor either. All the meds were late, by hours late. In an interview on 10/29/24 at 03:17 PM with the corporate registered dietitian (RD) AA revealed that residents with diagnosis of diabetes should get their insulin consistently, based on when they eat, we give insulin to what the order states. Record review of Resident #5's 'Medication Admin Audit Report' pages 1-72, dated from 10/1/2024 through 10/30/2024 revealed multiple days of late insulin medication administration. Record review of date of 10/28/2024 revealed that Lantus insulin was to be given at 8:30 AM and was administered at 10:30 AM by Registered Nurse P. Record review of Resident #5's 'Medication Admin Audit Report' pages 1-72 revealed multiple days of late insulin administration.

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Adira Nursing and Rehab	3200 State St Saginaw, MI 48602

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility 1) Failed to ensure proper labeling of medications in 5 of 5 medication carts, and 2 of 2 treatment carts, 2) Failed to properly secure/lock 2 of 2 treatment carts with medical supplies and prescription creams/ointments, 3) Failed to clean up loose medication tablets and debris, and 4) Failed to ensure proper completion of 2 temperature logs for medication refrigerators, resulting in the opened and undated medications, creams/ointments, with the potential for a resident to received medications/treatments with altered/decreased efficacy and potency, drug diversion or ingestion of unlocked medication/treatment carts, cross contamination and inappropriate temperatures. Findings include: Record review of the facility 'Storage of Medications' policy dated ,d+[DATE] revealed that medications and biological's are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized or administer medications. Temperature: all medications are maintained within the temperature ranges noticed in the United Stares Pharmacopeia and by the Centers for Disease Control (CDC). (c.) Refrigerated- 36 degrees Fahrenheit to 46 degrees Fahrenheit. (4.) Medications requiring refrigeration are kept in a refrigerator at temperatures between 36-degree Fahrenheit and 46-degree Fahrenheit with a thermometer to allow temperature monitoring Expiration dating (Beyond-use dating): (5.) When the manufacturer has specified a usable duration after opening the nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacture recommends another date or regulations/guidelines require different dating. Ensure proper labeling of medications and loose medications: Observation on [DATE] at 11:32 AM with Licensed Practical Nurse B of the short hall Coast unit medication cart revealed: Resident # 48 Humalog insulin pen open/used not dated on pen or package. Resident # 30 had Trelegy Ellipta inhaler ,d+[DATE].5 ,d+[DATE]mcg opened/used not dated on the inhaler or on the box. A single white tablet found in bottom of third drawer of the medication cart. Observation on [DATE] at 11:43 AM with Licensed Practical Nurse B of the long hall Coast unit medication cart revealed: Resident # 50 - Fluticasone 50mcg/ACT nasal spray was opened/used with no dates on box or bottle. Loose tablets were found in the medication drawers of large potassium tablet oblong shaped with a small white tablet found in the second drawer of the med cart loose. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 11:44 AM with Licensed Practical Nurse (LPN) Z of the secure dementia unit medication cart was found unlocked by that state surveyor. LPN Z was seated across the room at a laptop computer seated at a table. Observation of the dementia unit revealed there to be self-ambulating residents to ambulate the hallways. Observation of the medication cart second drawer of dementia unit medication cart revealed 3 loose white tablets. Observation of multi-dose medications for residents: Resident # 67 - Treglegy Ellipta inhaler ,d+[DATE].5 ,d+[DATE]mcg opened/used not dated on the inhaler or on the box. Resident # 58 Albuterol sulfate 90mcg/ACT inhaler opened/used not dated on the inhaler or on the box. Properly secure/lock 2 of 2 treatment carts: Observation with Registered Nurse (RN) P on [DATE] at 09:26 AM of the Bay treatment cart was found to be open with prescription medication creams/ointments noted in second drawer of the cart. Observations of the hallway noted Resident #73 and Resident #78 to self-ambulate the hallways. The state surveyor was able to open the drawers of the treatment cart and revealed: Resident # 15 - Clobetasol propionate 0.05% two tubes are open/used and there were no dates open dates on box or tubes. Resident # 80 -Mupirocin 2% ointment tube open and used with no open date on tube or box noted. Resident # 56 - Nystatin 100,000-unit bottle open and used no dates on box or on bottle. Resident # 27 - Gentamicin sulfate cream 0.1% tube is well used with no dates on tube or box. Resident # 141 - discharged on [DATE]- Lidocaine 3% Hydrocortisone 0.5% is used and open with no dates on tube or box noted. Resident # 46 -Betamethasone Valerate 0.1% cream opened and used with no open dates noted on tube or box. 2 tubes noted in cart with no dates. Registered Nurse P stated that the Bay one unit was a short-term rehab unit and had a wound care nurse on Tuesdays and Wednesday, and the wound care staff come around and use the treatment cart and the floor nurse do the dressing between visits. The treatment cart should be locked, and RN P locked the cart. Observation on [DATE] at 07:36 AM of the dementia unit medication cart located in the hallway with the computer screen open to Resident # 44 medication sheet. There was no nurse at the cart but was heard in a resident room. Observation on [DATE] at 07:46 AM with Licensed Practical Nurse (LPN) N of the harbor dementia unit treatment cart was found unlocked in dementia unit with prescription treatment ointments and creams noted: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident # 25 - Triamcinolone 0.1% cream opened well used and no date on tube or box. Two boxes found undated for the resident. Resident # 58- Mupirocin 2% ointment tube open and box not dated when opened. Resident # 63- Santyl 250 units ointment opened with no dates on tube or box. Record review of the facility 'Medication Administration' policy dated ,d+[DATE] revealed medications are administered in a safe and timely manner, and as prescribed. (19.) During administration of medications, the medication cart is kept closed and locked Failed to ensure proper completion of 2 temperature logs for medication refrigerators: Observation on [DATE] at 07:37 AM with Licensed Practical Nurse (LPN) N of the harbor dementia unit/Coast unit medication room refrigerator temperature log found clipped on the front of the refrigerator was noted to have missing days of monitoring. Record review of the Harbor/Coast unit medication refrigerator log dated [DATE] revealed multiple blank shifts of no temperatures documented. Record review of the Bay medication refrigerator log dated [DATE] revealed multiple shifts of low temperatures not in recommended range for medications. On [DATE] the temperature log noted 28 degrees Fahrenheit and a note that the temperature was turned up. On [DATE] documented temperature of 30 degrees Fahrenheit. [DATE] documented temperature of 32 degrees Fahrenheit. [DATE] documented temperature of 32 degrees Fahrenheit. Review of the [DATE] temperature log revealed 17 multiple shifts of low refrigerator temperatures documented. Record review of the facility 'Temperature Log' instructions: (3.) Refrigerator temperature must be between 36 degrees and 46 degrees Fahrenheit. Observation on [DATE] 09:44 AM with Licensed Practical Nurse (LPN) M of the Bay medication refrigerator revealed there to be Tuberculin B solution, RSV Arexvy 120mcg solution, multiple boxes of flu vaccine, multiple insulin pens on the middle shelf and Shingrix 50mcq and 4 boxes of influenza vaccine noted to the bottom of the fridge. Record review of the temp log clipped to the front of the refrigerator revealed the Temperature of the refrigerator was increased. In an interview on [DATE] at 09:49 AM with Registered Nurse (RN) F revealed that he had increased the medication refrigerators temperature on [DATE], stating it was his writing and that he noticed the refrigerator temp was too cold and turned up the refrigerator temp on that date [DATE] and reported it to the infection control nurse P. In an interview on [DATE] 10:20 AM with the corporate clinical specialist Registered Nurse A related to the Medication refrigerator temperature logs revealed that she had spoken to the pharmacy about the low temp and high temps of the refrigerator, that as long as immunizations are not crystallized the medications are good. State surveyor identified that the facility was not aware of the medication refrigerator lack of temperature monitoring for the Coast/Harbor unit, nor the inconsistent documented temps for Bay I & II units. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the consultant pharmacist summary dated [DATE], located in the pharmacy medication monthly review recommendation binders provided by the facility revealed: Both carts at Coast (unit) reviewed. Cart ,d+[DATE] undated insulin pens/vials. One expired insulin vial. Pink medication residue spilled on cart and dripped onto inhaler section of cart. Two undated inhalers. Undated applesauce. Cart 2 had two undated insulin pens. One expired vial. Two undated inhalers Medication storage room between Coast/Harbor reviewed. Refrigerator temperature log missing three dates.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to provide dental services to one resident (R19) of one resident reviewed for dental services, resulting in the resident not receiving routine dental services since admission. Findings include: Resident #19 (R19): R19 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cerebral palsy, dysphagia, anxiety disorder and need for assistance with personal care. R19 has a BIMS (brief interview for mental status) score of 13, indicating they are cognitively intact. R19 has a guardian due to the inability to make their own medical decisions. On 10/29/24 at 09:27 AM, R19 was asked if they had any concerns they would like to discuss. R19 stated they would like to see the dentist. R19 stated they have no issues with their teeth, but they have some fake teeth. R19 was asked if they had seen the dentist since being in the facility. R19 stated they haven't seen the dentist since being here. On 10/30/24 at 03:38 PM, an interview was conducted with SW S. This surveyor asked SW S if R19 had seen the dentist since they had been admitted to the facility. SW S was unsure but stated they would reach out to the contracted dentist for the facility and let me know when they hear back. On 10/30/24 at 04:10 PM, SW S came to this surveyor and said the dentist had gotten back to them and that R19 was placed on the list to be seen by the dentist next week. SW S was asked again if R19 has ever been seen by the dentist while at the facility. SW S stated no, R19 hasn't been seen by the dentist. SW S was asked if residents receive a form to fill out to consent to ancillary care such as the dentist. SW S stated yes, they fill out a form on admission to consent to ancillary services such as the dentist. On 10/30/24 at 04:15 PM, record review of the EMR (electronic medical record) revealed a dental consent form for R19, signed and dated 11/2/22, the boxes to consent to or decline dental care services were blank. Review of the policy titled, Dental Services reviewed 3/24, revealed: Policy Interpretation and Implementation 1. Routine and emergency dental services are provided to our residents through: a. A contract agreement with a licensed dentist that comes to the facility; b. Referral to the resident's personal dentist; c. Referral to community dentists; or (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Referral to other health care organizations that provide dental services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to consistently offer and provide snacks at bedtime for seven residents (#4, #5, #28, #32, #37, #39, #40) of 7 residents reviewed for nightly nutrition. Resulting in, feelings of frustration, unmet needs and residents going longer than 14 hours between dinner and breakfast. Findings Include: During a confidential Resident Council meeting held on 10/29/2024 at 11:30 AM, the twelve residents in attendance were queried if nighttime snacks are offered by facility staff. Eleven of the twelve residents in attendance stated they are not consistently being offered snacks at night. They shared at times when they request snacks, the staff will say they do not have any available snacks for the residents. On 10/30/2024 at 4:22 PM, Dietary Manager I reported he was aware of resident concerns surrounding nighttime snacks as they have mentioned it during food council meetings. On 10/31/2024 at approximately 8:15 AM, a review was conducted of the last 6 months of resident council notes, and it revealed the following regarding nighttime offering of snacks. October 1, 2024: .See concern form about availability of snacks and juices .: September 3, 2024: See concern form about availability of snacks & juices. Message given to Dietician about HS (night) snacks . July 2, 2024: .There are no snacks at night on the Coast . June 4, 2024: .stated we don't always get fresh water, something its first shift that don't it out and other times its second shift that forgets to give us water . On 10/31/2024 at approximately 8:30 AM, a review was conducted of the last 6 months of food council notes, and it revealed the following regarding resident complaints regarding nighttime snacks: July 23, 2024: .some residents sat there isn't food for snacks in the fridge . August 20, 2024: .Some residents say there isn't food for snacks in the fridge. We deliver snacks around 4 PM to make sure they last through the night. That way there should be enough to get through the night, there usually are snacks in the fridges when I get in ad do my rounds in the morning . September 17, 2024: .Snacks are inconsistent. Some residents say they are offered a snack while others are not. Snacks are usually in the refrigerators in the AM when I do my rounding. My best guess is that the CNA's are not offering residents snacks consistently at night . (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review was completed of resident's nighttime snack documentation over the past 30 days, and it was evident snacks were not being consistently offered to residents as they stated in Resident Council. The documentation showed the following: Resident #4 Over the last 30 days Resident #4 was only offered a snack eight times. Resident #5 Over the last 30 days Resident #5 was only offered a snack thirteen times. Resident #28 Over the last 30 days Resident #28 was only offered a snack eighteen times. Resident #32 Over the last 30 days Resident #32 was only offered a snack fourteen times. Resident #37 Over the last 30 days Resident #37 was only offered a snack eight times. Resident #40 Over the last 30 days Resident #40 was only offered a snack fourteen times. On 10/31/2024 at 8:30 AM, the Administrator was queried regarding consistent offering of nighttime snacks to residents. The Administrator stated she believes facility staff wait until residents request the snack versus offering them. Corporate Clinical Nurse A stated while that may be true, there are times when snacks are not available in the refrigerator, as they have received phones alerting them to such afterhours. 49944 Resident #39 (R39): R39 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include type 2 diabetes mellitus with hypoglycemia (low blood sugar) chronic kidney disease and hyperlipidemia. R39 has a BIMS (brief interview for mental status) score of 9, indicating they have moderate cognitive impairment. On 10/28/24 at 02:15 PM, R39 was asked about the food at the facility. R39 says the food is good, but sometimes they don't give out night snacks. R39 stated they are diabetic and would really like to have a night snack because they have low sugar. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 03:09 PM an interview was conducted with RD (registered dietitian) DD. RD DD was asked if all residents offered a night snack. RD DD stated, to my knowledge yes. RD DD was asked if there is a system in place for diabetic residents to get snacks at night. RD DD stated there is an order put in place to ensure that diabetic residents get snacks. Snacks go in the refrigerator on the unit around PM, the aides know the combination to the lock to access the refrigerator to get the snacks. On 10/29/24 at 03:27 PM, record review of the physician's orders revealed an order for diabetic HS (night) snack, dated 06/26/24. Record review of the September MAR (medication administration record) for R39 revealed that R39 went five days in a row (September 18-22) with no snack consumption. The other days of the month revealed 90%-100% consumption of night snacks. Review was completed of the facility's meal service times which are as follows: Breakfast: 7:00 AM- 8:00 AM Lunch: 12:00 PM - 1:00 PM Dinner: 5:30 PM-6:30 PM There is exactly 14 hours between the beginning of dinner service and breakfast service with residents not being offered a nourishing snack Review was completed of the facility policy entitled, Snacks (Between Meal and Bedtime), Serving, revised 3. 2023. The policy stated, The purpose of this procedure is to provide the resident with adequate nutrition . The policy does not address who is responsible for offering and preparation of the snacks.

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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** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome and process surveillance, accurate data collection/documentation/analysis and failed to ensure appropriate hand hygiene and disposal of soiled linens/waste products, resulting in a lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis. and the likelihood for spread of microorganisms and illness to all 84 facility residents. Findings include: Facility line listing documentation since the last annual survey were requested from the facility Administrator and Infection Control (IC) Registered Nurse (RN) P on 10/29/24 at 12:07 PM and 12:10 PM respectively. On 10/29/24 at 12:44 PM, IC RN P provided the line listing documentation for June and July 2024. On 10/29/24 at 2:55 PM, the only requested line listing documentation received was for June and July 2024 and an interview was completed was completed with IC RN P. When queried regarding the status of the line listings, IC RN P revealed they took over (IC) in June (2024) and were unable to locate all the requested line listings. IC RN P revealed the Acting Director of Nursing (DON) and Administrator were assisting them to look but they had also been unable to locate the information. When asked why they did not send August, September, and October 2024 as that was after they took over as the IC nurse, IC RN P revealed they were still working on October but did not provide further explanation. IC RN P was asked to provide what line listing documentation they had for review. A review of facility provided Infection Control line listing documentation from December 2023 to October 2024 revealed the facility did not provide line listing documentation for January, February, May, and September 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 5:20 AM on 10/30/24, an observation of the locked dementia unit of the facility was completed. The treatment cart was observed in the middle of the hallway, between rooms [ROOM NUMBERS]. The cart was unlocked and unattended by staff and there were unfolded and rumpled towels, unfolded briefs, and water cups sitting on top of the cart. Multiple open garbage bags, containing soiled items and linens were sitting on the floor in the hallway between rooms [ROOM NUMBERS]. Licensed Practical Nurse (LPN) KK was observed by the medication cart and an interview was completed. When queried regarding the treatment cart being in the middle of the hallway, LPN KK replied that the Certified Nursing Assistants (CNA) were using the cart. When queried if the rumpled towels on top of the cart were dirty, LPN KK replied, They are now. I will have them get rid of them. When asked if all the items on the top of the cart were contaminated, LPN KK did not provide a response but indicated the CNA should not be using the cart and they would address it. LPN K was then asked what the open garbage bags were on the floor and revealed the CNA leave the bags there on night shift and put their garbage in them when they do their check and changes and then take the bags to the soiled utility all at once. When queried if they were saying the bags were full of soiled incontinence products and linens, LPN KK confirmed. LPN KK was then asked if it was sanitary and good IC to place multiple residents soiled items together on the floor and said it was not. LPN KK revealed the CNA were in rooms but verbalized they would speak to them. At 6:05 AM on 10/30/24, the open garbage bags containing soiled incontinence products and linens remained in the same place on the floor. At this time, CNA MM was observed walking down the hall with soiled (inside out/removed) gloves in their hands. CNA MM walked past the garbage bags and approached the room CNA LL was in. CNA LL was then observed exiting the room they were in after providing care. CNA LL was observed removing their gloves, touching items in the room, and not performing hand hygiene before entering another room to assist a different resident. An interview was conducted with the facility Administrator on 10/30/24 at 6:58 AM. The provided IC line listing documentation was reviewed with the Administrator at this time, and they confirmed Jan January, February, May, and September 2024 were not included. When asked why, the Administrator revealed they were unable to locate documentation maintained by the prior IC nurse. The facility IC monthly summaries since the last annual survey were requested at this time. An interview was completed with IC RN P on 10/30/24 at 11:16 AM. When queried regarding process surveillance and IC audits completed on night shift, IC RN P revealed they frequently work night shift due to staff call ins/staffing needs and they are able to observe what occurs even if they do not complete audits. When queried if they observed any concerns with staff placing garbage bags on the floor in the hall containing multiple residents soiled items, IC RN P stated, I know some do that. When queried regarding the risk of microorganism transmission from an IC point of view, IC RN P verbalized understanding and stated Staff were educated a couple weeks ago related to the bags on the floor. IC RN P verbalized staff would need to be educated again. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview and review of facility IC data was completed with IC RN P on 10/31/24 at 8:08 AM. When queried regarding process surveillance and IC audits completed on night shift, IC RN P revealed they frequently work night shift due to staff call ins/staffing needs and they are able to observe what occurs even if they do not complete audits. IC RN P then stated, Two nurses called in last night and I worked all day yesterday until midnight. IC RN P was asked when they came back to work and replied, I got here about 7:30 AM. When queried if they observed any concerns with staff placing garbage bags on the floor in the hall containing multiple residents soiled items, IC RN P stated, I know some do that. When queried regarding the risk of microorganism transmission from an IC point of view, IC RN P verbalized understanding and stated Staff were educated a couple weeks ago related to the bags on the floor. IC RN P indicated they would need to educate staff again. When queried regarding observations of staff not performing hand hygiene including not using Alcohol Based Hand Sanitizer, IC RN P replied, I have observed instances where not performing (hand hygiene) during audits. When queried if they noticed a trend in infections and lack of hand hygiene, IC RN P verbalized they had not. When queried regarding the number of Urinary Tract Infections (UTI) at the facility, IC RN P stated, Yeah, we go in spurts. Maybe in august we had a group of women who all had e-coli (bacteria commonly found in the intestines). When asked if they were able to identify a cause/trend for the infection in the group of women, IC RN P revealed they did not. IC RN P was then informed of multiple observations of Resident #81 and Resident #11's indwelling urinary catheter drainage bags being on the floor. When queried, IC RN P revealed both Resident's were recently treated for UTI. When asked if the bags and tubing being on the floor may be contributing to the infection, IC RN P verified it could be. When queried regarding the months that the line listings were not provided for, IC RN P confirmed they were unable to locate the documentation. When asked, IC RN P verbalized understanding of the importance of maintaining the documentation for review. The facility line listings contained sections titled, Covid-19, Influenza, Antibiotics, Antifungals/Antivirals, Carry Over, and Prophylactic with correlating resident infections included under each section. The July 2024 IC Line listing was reviewed with RN P at this time. The line listing document included three Residents who tested positive for Covid-19. The room number of the residents and/or any room changes were not included on the line list form. When queried how they were able to easily see and track potential spread without the room numbers, IC RN P verbalized they could not and would add the room numbers to their line list. When asked what the date on the line list indicated, IC RN P replied, Date they tested positive. When queried if the residents had any signs/symptoms of infection prior to testing positive, IC RN P stated, We had an employee test positive and then tested residents. The line listing revealed five facility staff tested positive for Covid-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All residents including on the line listing, with the exception of the those who tested positive for Covid-19, were listed as receiving Antimicrobial treatment. When queried how they track residents who may have a potential infection and/or an infection that does not require Antimicrobial treatment, IC RN P stated, We don't have a section for that. With further inquiry, IC RN P revealed they were not tracking and monitoring potential infections. When asked what the date on the line listing signified, IC RN P revealed it was the date which treatment was initiated. When asked why the symptom onset date was not included, IC RN P replied, Because of the charting. With further inquiry, IC RN P revealed the facility staff do not consistently chart and do not consistently chart in the same areas so they are often not aware an Antimicrobial has been started until after it is ordered and treatment had been initiated. When asked how they were able to accurately identify possible transmission and trends if they are not looking at the date when symptoms began, IC RN P verbalized understanding and revealed they had not considered that as they were completing the line listing form as they were instructed to do. A review of the monthly summary for July 2024 revealed the total number of infections did not match the total number of infections included on the line listing. When asked why the numbers did not correlate, IC RN P stated, I was not to include residents on the summary that I couldn't guarantee were a true infection. IC RN P was then asked how they determined which residents to exclude from the monthly IC data reporting summary and stated, So if I didn't have a wound culture or actual C&S (Culture and Sensitivity) and only symptoms I didn't count them. When queried if the residents who were not counted were still receiving Antimicrobial medications, IC RN P confirmed they were. When asked what criteria they utilized for determining if an infection meets criteria, IC RN P replied, McGeer. When queried why the McGeer section on the line list was not completed for all residents listed, an explanation was not provided. When asked if they were tracking infections or antibiotics/Antimicrobial treatments, IC RN P verbalized the IC tracking completed on the line listing is reactive rather than proactive to identify potential infections early and prevent potential spread. Review of facility provided policy/procedure entitled, Surveillance for Infections (Reviewed 4/24) revealed, The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAI) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions 3. Infections that will be included in routine surveillance include those with: a Evidence of transmissibility in a healthcare environment; b. Available processes and procedures that prevent or reduce the spread of infection; c. Clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTI, C. difficile); and d. Pathogens associated with serious outbreaks . 4. Infections that may be considered in surveillance include those with limited transmissibility in a healthcare environment; and/or limited prevention strategies. 5. Nursing Staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the Charge Nurse as soon as possible . 8. The Charge Nurse will notify the Attending Physician and the Infection Preventionist of suspected infections . Data Collection and Recording: 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a. Identifying information (i. e., resident's name, age, room number, unit, and Attending Physician); b. Diagnoses; c. admitted , date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test); d. Infection site . e. Pathogens; f. Invasive procedures or risk factors; g. Pertinent remarks . h. Treatment measures and precautions . 22927 Dressing changes cross contamination: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 10/30/24 at 09:48 AM with Licensed Practical Nurse (LPN) M and LPN G with Resident #9's lower leg dressing change revealed a barrier was placed on over bed table, all dressing items fell from the plastic bag on to the floor and were picked up and placed back on the barrier. Observation on 10/30/24 at 09:50 AM of Resident #9's urinary catheter site. Observed right lateral foot/leg, LPN G reached into her uniform pocket and took scissors from her pocket and gave to LPN M. Licensed Practical Nurse (LPN) M used the scissors to cut through the old gauze dressing that was bloody with serosanguinous drainage. LPN M stated that the wounds were from poor circulation and that the resident was admitted with the wounds. Observation of open area to lateral leg, lateral ankle, and lateral right heel and toes are black. LPN M applied wound cleaner derma cleanse, sprayed each wound and wiped with gauze, resident winced with pain. LPN M continued with cleaning other wounds. Wound treatment of calcium alginate was placed into the wounds. LPN M stated the dressing was changed yesterday for all wounds. ABD dressings to cover wounds, wrapped with gauze wrap, taped, dated and initialed. In an interview on 10/31/24 at 11:02 AM with the Infection Preventionist (IP) P was asked about cross contamination from scissors during dressing change was explained. IP P stated that the scissors should have been wiped down with alcohol swabs, or we have the sterile suture remover kits with the scissor in the kit, that's what they should have used. Medication Administration: Observation and interview on 10/29/24 at 07:15 AM with Licensed Practical Nurse (LPN) B observation of the coast Medication room medication on fridge temp log was not consistently filled out/documented temp checks. On 10/29/24 at 07:20 AM with LPN B of the supply room between the Coast and Bay units revealed tube feeding supplies. LPN B retrieved an instant ice bag and walked back to Resident #50 room and applied to the residents left knee. LPN B walked back to the cart, and began medication pass with no hand hygiene. Observation 10/29/24 at 07:32 AM with LPN B did not do hand hygiene prior to medication administration after going to med room and supply room and back to the medication cart. Observation on 10/29/24 at 07:35 AM with LPN B of top drawer on Coast medication cart noted two clear plastic medication cups with crushed medications. LPN B stated the medications were for Resident # 21Fluoxetine, second cup with whole tablets of Coreg and clozapine in cups in top drawer there were no identification or resident name on the cups.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on interview, and record review the facility failed to implement and maintain an Antibiotic Stewardship Program and failed to ensure accurate and timely monitoring and documentation of antibiotic use resulting in the potential for inappropriate antibiotic utilization and the worsening or non-improving infections for all 84 Residents residing within the facility as well as the potential for antibiotic resistance. Findings include: A review of facility provided Infection Control documentation from December 2023 to October 2024 revealed the facility did not provide line listing documentation and/or Antibiotic Stewardship documentation for January, February, May, and September 2024. An interview and review of facility IC data for July 2024 was completed with IC RN P on 10/31/24 at 8:08 AM. When queried regarding the facility antibiotic stewardship program, IC RN P revealed they track antibiotic use on the monthly line list. A review of the July 2024 Line List revealed 28 antibiotics were ordered and initiated to 19 separate residents during the month. Of the residents listed, six received multiple antibiotics, the following was identified: - One resident was treated with three different antibiotics, which were initiated on two separate dates for a Urinary Tract Infection (UTI). - One resident was treated with two separate antibiotics for a UTI. The antibiotics were started the same day and one was listed as being discontinued due to an allergy but the date of discontinuation was not specified. - One resident received three antibiotics due to being treated for C-diff twice as well as a UTI. - One resident was receiving two antibiotics per (hospital) discharge summary for a wound infection and pneumonia. - One resident was receiving two separate antibiotics for an elevated WBC (White Blood Cell Count) per the hospital Discharge summary. - Another Resident was listed as receiving three separate antibiotics for a wound infection. Per the line listing, two antibiotics were started and then discontinued when the wound culture and sensitivity came back. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the line listing, all residents and antibiotics met McGeer criteria with the exception of four antibiotics, for three residents not specifying if criteria was met or not met. When asked what criteria they utilized for determining if an infection meets criteria, IC RN P replied, McGeer. When queried why the McGeer section on the line list was not completed for all residents listed, an explanation was not provided. The list also included five antibiotics, for two residents, specified as Carry Over infections and one resident was listed as receiving a prophylactic antibiotic. Review of the July Monthly Infection Summary detailed there were 24 total infections documented of which 16 were facility acquired. The Summary did not include information pertaining to the total number of residents who received antibiotics and if those residents' met criteria for treatment. When queried regarding the discrepancy in the number of residents included on the antibiotic list and the number included on the summary, IC RN P stated, I was not to include residents on the summary that I couldn't guarantee were a true infection. IC RN P was then asked how they determined which residents to exclude from the monthly IC data reporting summary and stated, So if I didn't have a wound culture or actual C&S (Culture and Sensitivity) and only symptoms I didn't count them. When queried if the residents who were not counted were still receiving antibiotic medications, IC RN P confirmed they were. IC RN P was asked if they were saying they did not include residents on the summary who did not meet criteria to receive an antibiotic and reiterated they were doing what they were instructed to do and not including anyone who was not a True infection. When queried how that was ensuring appropriate use of and accountability for antibiotics, IC RN P was unable to provide further explanation. When queried regarding the process/procedure for antibiotic initiation and how they are made aware that an antibiotic is ordered, IC RN P revealed they work a lot of off hour shift to cover staffing needs which makes it difficult. IC RN P revealed facility staff do not dependably document and do not consistently chart in the same areas, so they are often unaware that an antibiotic has been started until after it is ordered, and treatment had been initiated. When asked how they are monitoring and ensuring appropriate use when they are not aware of the medication until after it has been started, IC RN P confirmed they could not. No further explanation was provided. Review of facility provided policy/procedure entitled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes (Reviewed: 1/24) revealed, Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship . 1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. 2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics . 38471 Resident #58: During initial tour on 10/28/2024, Resident #58 was observed resting in bed watching television. The resident was pleasant and did not appear to be in any distress. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/2024 at approximately 7:30 AM, a review was completed of Resident #58's medical record and it revealed she initially admitted to the facility on [DATE] with diagnoses that included, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Pressure Ulcer of Sacral region, muscle wasting and atrophy and Acute Kidney Failure. Further review of Resident #58's records yielded the following: Physician Orders: Doxycycline Monohydrate Oral capsule 100 MG -twice a day was ordered on 10/22/2024 by Physician EE and inputted by Unit Manager M. October 2024: MAR (Medication Administration Record): Doxycycline Monohydrate Oral capsule 100 MG (milligrams)- give 100 mg by mouth two times a day for wound infection for 7 days. State date 10/23/2024/end date 10/29/2024. Progress Notes: There was no progress notes related to signs and symptoms Resident #58 displayed or other reasoning behind starting the resident on an antibiotic. Laboratory Results: There were no laboratory results located that indicated the facility collected a specimen to complete a C & S (culture and sensitivity) to determine which organism they were treating or determine which antibiotic would be most susceptible to said organism. On 10/30/2024 at approximately 7:40 AM, Unit Manager/Wound Nurse M stated Physician EE began the antibiotic due to increased odor and drainage. Unit Manager M was asked if during the wound assessment if a culture was completed and she stated it was not. Unit Manager EE wound assessment from 10/22/2024 was reviewed, and it stated the resident was on the antibiotic due to wound infection. On 10/30/2024 at 9:40 AM, Infection Preventionist P was asked for the culture and sensitivity results for the administration of Doxycycline for Resident #58. Preventionist P reviewed the resident's chart and shared the last set of laboratory tests are from 8/29/2024 with no specimen being collected for her most recent antibiotic usage. Preventionist P further reviewed the resident's chart and could not locate any notes from the physician regarding the reasoning for administration. Preventionist P was not able to explain to this writer Resident #58's need for an antibiotic nor find any notes regarding criteria was met prior to administration. Preventionist P explained she was not aware the resident was on an antibiotic and she was not on her October 2024 line listing. She further expressed many times residents are added to the line listing after the fact, as she works the floor frequently and does not have the designated time to identify, monitor and document infections within the facility. Preventionist P stated she has no documentation related to which organism was being treated with the Doxycycline and further shared Resident #58 did not meet McGreer's criteria for antibiotic usage. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/2024 at 7:40 AM, Unit Manager/Wound Nurse M stated Physician EE began the antibiotic due to increased odor and drainage. Unit Manager M was asked if during the wound assessment if a culture was completed and she stated it was not. Unit Manager EE wound assessment from 10/22/2024 was reviewed, and it stated the resident was on the antibiotic due to wound infection.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37668 Based on interview and record review, the facility failed to implement and operationalize policies and procedures for vaccination administration for three residents (Resident #1, Resident #56, and Resident #75) of five residents reviewed, resulting in the lack of administration of desired and appropriate vaccinations, and the potential for disease acquisition, transmission, and decline in overall health status. Findings include: A review of the facility vaccination program was completed with Infection Control Registered Nurse (RN) P on 10/31/24 at 8:08 AM. When queried regarding facility policy/procedure related to vaccination administration, RN P revealed they obtain all vaccine consents and review prior vaccination administration. Resident #1: Review of Resident #1's immunization consent documentation revealed the Resident wanted the Influenza and Pneumonia vaccinations. The Resident's Immunization administration documentation in the Electronic Medical Record (EMR) revealed the Resident had received the Influenza vaccine but did not receive the Pneumonia vaccine. When queried why the Pneumonia vaccine was not administered, RN P revealed the vaccine order was entered but not administered as ordered by the floor nursing staff. Resident #56: Review of Resident #56's vaccine administration documentation revealed a medication administration note which detailed, Education Provided . Prevnar 13 (Vaccine) Administered . When asked why Prevnar 13 education was provided/administered, RN P stated, I don't know. It should have been (the Prevnar 20) vaccine. Review of the Vaccine order and Medication Administration Record (MAR) specified Prevnar 20 vaccine was ordered and administered. When asked why the administration and education documentation did not correlate, RN P was unable to provide an explanation. When queried what Vaccine Information Statement (VIS) had been provided, RN P revealed the facility did not document the VIS version provided when a vaccine is administered. With further review of Resident #56's pneumonia vaccine order, RN P revealed they did not enter the vaccine order. RN P stated, Vaccine order entered by (Unit Manager [Licensed Practical Nurse] M). With further inquiry, RN P stated, No documentation of follow-up monitoring after the vaccine was administered due to the way the order had been entered. Resident #75: Review of Resident #75's immunization consent documentation revealed the Resident wanted the Pneumonia vaccination. A review of the Resident's health care provider orders and MAR revealed the Resident never received the vaccine. When asked the reason the vaccine was not administered, RN P confirmed the medication was not administered and stated, No documentation of reason not administered in the progress notes. RN P confirmed the Resident wanted the vaccination and the vaccination was available but not administered. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided policy/procedure entitled, Pneumococcal Vaccine (Reviewed 9/24) revealed, All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. 2. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission. 3. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. (See current vaccine information statements at https://www.cdc.gov/vaccines/hcp/vis/index.html for educational materials.) Provision of such education is documented in the resident's medical record. 4. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. 5. Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 6. For each resident who receives the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination are documented in the resident's medical record. 7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination .