STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235256	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dimondale Nursing Care Center	4000 N Michigan Road Dimondale, MI 48821

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 27306 Based on observation, interview and record review, the facility failed to ensure their rights to self determination were honored for three residents (resident #15, #63 and #97) of six residents reviewed and facility census of 135 for self determination. Findings Include: On 6/11/24 at approximately 8:30 am, upon entering the facility entrance door, 2 separate typed signs were observed in clear plastic protector and posted on the main entrance door, the first sign read !!ATTENTION!! RESIDENTS & FAMILY DOORS LOCK AT 8 PM ALL RESIDENTS MUST BE INSIDE BY 8 PM The second sign, also in a plastic protector and taped to the door read Resident Visiting Hours Monday-Sunday 8:00 AM - 8:00 PM Resident #15 (R15) Review of the clinical record including the Minimum data Set (MDS) dated [DATE] reflected Resident # 15 (R15) was a admitted to the facility 09/09/23 with diagnosis that included lung cancer, depression and anxiety, further review of the clinical record reflected R15 was receiving hospice care. R15 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 06/11/24 at 12:29 PM, R15 was interviewed at bedside and reported being admitted to the facility several times (returning home) and normally has no issues, however upon the most recent readmission in September of 2023, R15 reported the doors are locked at 8:00pm. R15 reported her family was not allowed to visit and she was not allowed to go outside past 8:00pm. R15 elaborated that she felt like she was treated like a child, Do you know how many nights I sit in this room looking at sky and its still daylight and I think I will go outside but I cant because I am locked in here. R15 stated she did report this concern with Nursing Home Administrator A (NHA) A last fall but didn't get a response. R15 voiced concern of the the Fourth of July coming and not being allowed to see fireworks for the holiday due to the rule of being made to stay in after 8:00 pm. Resident #63 (R63) Review of the clinical record including the Minimum Data Set (MDS) dated [DATE] reflected Resident # 63 (R63) was admitted in 2018, R63 scored 15 out of 15 (cognitively intact) . (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/11/24 at 11:54 AM Resident # 63 (R63) was interviewed in her room, she was observed to have tanned skin and verbalized that she liked to spend her days outside in the fresh air. R63 stated she wanted to make a complaint about the curfew and elaborated that she would like to sit on the patio in the evening and enjoy the summer weather especially since it was still daylight past 8:00 PM, but had to be in by 8:00 PM per the facility rule. 34705 Resident #97(R97) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R97 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included lung cancer with secondary cancer to liver and bone, hypertension (high blood pressure), history of falls with fractures, blood clots, anxiety and depression. The MDS reflected R97 BIM (assessment tool) score of 15 which indicated her ability to make daily decisions were cognitively intact. The MDS reflected no behaviors including unsafe wandering. During an observation on 6/11/24 at approximately 8:45 am, upon entering the facility entrance door, 2 separate typed signs were observed in clear plastic protector and posted on the main entrance door, the first white sign read !!ATTENTION!! RESIDENTS & FAMILY DOORS LOCK AT 8 PM ALL RESIDENTS MUST BE INSIDE BY 8 PM. The second green sign, also in a plastic protector and taped to the door read Resident Visiting Hours Monday-Sunday 8:00 AM - 8:00 PM. During an observation on 6/11/24 at 10:42 AM, the white sign that read, !!ATTENTION!! RESIDENTS & FAMILY DOORS LOCK AT 8 PM ALL RESIDENTS MUST BE INSIDE BY 8 PM had been removed and green visitation sign remained posted on the entry door. During an observation and interview on 6/11/24 at 4:45 PM, R97 was in room with family and appeared calm, pleasant and able to answer questions without difficulty. R97 reported was upset that facility residents, including herself had to be inside the building by 8:00 p.m. every night because the doors locked. R97 reported liked to go outside and during the summer it is daylight much later than 8:00 p.m. R97 reported signs on the doors that reflected rules of when to be back inside the facility. R97 reported this was her home and she should not be locked in or out of her home. R97 reported the same rules apply to visitors with posted sign on door of visiting hours between 8:00 a.m. and 8:00 p.m. and had been same rules since she admitted to facility. R97 reported their are times that residents are outside after 8:00 p.m. and the doors are locked. R97 daughter reported there had been several times they would have liked to keep R97 out past 8:00 p.m. but that was the rules so they comply but difficult with evening schedules. During an interview on 6/13/24 at 3:01 PM, R97 reported two residents were locked out of facility last evening at 8:00 p.m. R97 reported not aware of any system to get back in facility similar to door bell. R97 stated, They treat us like we are prisoners that pay a good amount of money to stay hear. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/14/24 at 2:01 PM, Nursing Home Administrator (NHA) A removed sign from the main entry door and reported the facility did not have rules for visiting hours or that residents had to be in the facility by 8:00 p.m. NHA A reported the doors are locked from 8:00 p.m. until 8:00 a.m. but system in place that staff can be alerted to open the doors but no reception staff at those times. NHA A reported was unaware residents were under the impression they had a curfew and could see that by the posted signs they might think that. NHA A reported planned to provide staff, resident and family re-education related no visitation or resident hours rules. NHA A reported was unsure who removed the white posted sign on 6/11/24 after survey entrance.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview and record review, the facility failed to act promptly on grievances and or concern forms reported in resident council meetings and provide responses and resolutions to 52 grievances filed in the last six months, as reported during a confidential resident council interview, in a total sample of 27 residents and a total census of 135 residents, resulting in unresolved resident concerns and decreased quality of life. Findings include: During a confidential interview with resident council group on 06/12/24 at 11:19 AM where 11 residents attended. The last six-months concern forms were reviewed and discussed for resolution. Concerns shared during private meeting. 1) Wheelchair concerns needed repair for over a month. 2) Call light response time. 3) Male resident had a female shirt put on him. 4) Female had a fall in her bathroom, pulled the call light for help, the floor was slippery was the reason she fell . 5) They are always told its the states fault, 6) Facility staff will go into residents' room and look through their things without permission and remove personal things from their rooms. 7) Not using dining room, not enough staff, must eat in their rooms. 8) Food- cold food on west hall, not receiving meals on time, they are late daily. 9) If they order a chef salad, must wait a long time to get it. Concern forms reviewed from the last 6 months. 1) Female missing showers 2) Missing hearing aides 3) Roommate woke up screaming in the night. 4) Room not put back together after cleaning (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	5) [NAME]- Miscommunication at shift change 6) Glasses need adjusted 7) Missing red bra. 8) Missing clothes 9) Male missing showers 10) Receiving food late 11) Male driving wheelchair too fast in hall 12) Requested roommate change 13) Does not want to be wake up in the night 14) Lab comes too early to draw blood. 15) Male missing clothes 16) Neighbor's TV is loud 17) Does not want to be woke up during the night/early morning. 18) Male missing items 19) Staff talking loud in the hallway 20) Lost DVD movie 21) Male missing items 22) Wheelchair nears repair 23) Female missing items 24) Missing personal wheelchair 25) People coming in his room at night 26) Missing laptop 27) Trash can missing 28) Call light respond time (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	29) Broken pepper grinder 30) Needed a different bed 31) Male not getting showers 32) Smokers sit by the front door 33) Glasses broken 34) Missed scheduled appt 35) Needs help with shower 36) Urinal not emptied at night 37) Missing money 38) Trash not getting emptied 39) Assist with standing 40) Missing/faulty lamp 41) Evening activities 42) Food choices 43) Mattress needs replaced 44) Not getting food and fresh water 45) Male missing shower- ongoing 46) Missing alarm clock 47) Male missing clothes 48) Computer not working 49) Call light not answered/missed shower- ongoing 50) Resident living in the dining room 51) Facility not addressing concerns 52) Roommate TV is load (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 06/14/24 at 08:34 AM, Laundry Manager (LM) Ostated the inventory sheets for all of the personal belongings are kept in the soiled utility room with the labeling sheets. RN P stopped during this interview and stated she would find out where they are kept as she doesn't think they have ever been in the medical record. During an interview on 06/14/24 at 08:57 AM, Executive Director in Training (EDIT) Q stated they receive the concern forms, and he logs them. EDIT Q stated he follows up with the resident, offers a solution, if residents are satisfied then he will ask them to sign off on the concern form. Writer asked EDIT Q what they were doing to track these concerns and audit to see if there are repeated concerns being reported. EDIT Q stated he takes them to QA meetings; specific managers ask the residents about their concerns. EDIT Q also stated they had started a new program called support and services form. Writer asked to see the process and audits for this program. EDIT Q stated they had a four-week cycle to look for all grievances. Writer asked EDIT Q to provide this data. Record review revealed EDIT Q has provided blank copies of the support and service form at 0913 AM on 06/14/24. On 06/14/24 at 2:42 PM, Writer emailed NHA A requesting the completed support and service forms that they had been using. Writer asked NHA A what he did to correct the problems and what was the root cause? Writer received this email on 06/14/24 at 02:50 PM from NHA A stating, part of the idea/inception of this new program for us is to have immediate resolution. In essence to take care of a problem before it's a problem. With that said managers are supposed to address issues right there at the bedside. If for some reason they were unable to do so then they were instructed to complete a grievance form. Record review of the completed support and service forms revealed two forms were not dated, one was dated 05/30/24, 06/03/24, 06/06/24, 06/07/24, 06/11/24 over the course of 12 days. It revealed there were still concerns identified during this time and the forms did not reveal any follow up, correction or identifying the root cause to these concerns. This new program appears to have been started during the last month, but did not address the ongoing concerns over the course of the last year leaving residents with ongoing concerns, potential for unmet needs and dissatisfaction with the facility.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview, and record review, the facility failed to provide timely, appropriate care and services to meet the needs of three of 27 residents reviewed for quality of care (Resident #11, Resident #15 and Resident #121), from a total of 27 sampled residents, resulting in these residents potentially not receiving adequate and/or appropriate care required for them to maintain or achieve their highest practicable physical well-being. Findings Include: Resident #11 (R11) Review of the medical record reflected R11 was an initial admission to the facility on [DATE] with a readmission on 04/25/24. Diagnoses of Acute and Chronic Respiratory Failure with Hypoxia, Muscle Weakness, Chronic Obstructive Pulmonary Disease, Acute on Chronic Systolic (congestive) Heart Failure, Hemiplegia and Hemiparesis following Cerebral Infarction (stroke) affecting the right side and Peripherial Vascular Disease. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/06/2024, revealed R11 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R11 requires assistance with care provided for his lower extremities. During an interview and observation on 06/12/24 at 08:12 AM, R11, stated he wanted to go to the hospital because he was short of breath, he also stated the nurse working that shift checked his vital signs including the O2 sats. He stated that he ended up calling 911 to come and get him, because the facility did not help get him transferred to the hospital. R11 stated the EMS called the facility to see if he really needed to be transferred because he had called 911 before. R11 stated he finally was sent out to the hospital and was admitted on [DATE] through 04/25/24. Record review revealed R11 was admitted to the hospital on 04/14/24 due to acute hypoxic respiratory failure and decompensated ejection fraction (heart failure with reduced ejection fraction) as well as lower extremity cellulitis. R11 required increased oxygen requirements of 4 liters per minute (lpm) with a baseline of 2 lpm. R11 received IV diuresis (kidneys filter too much fluid from the body) and oxygen requirements helped with dyspnea (shortness of breath) and peripheral edema (accumulation of fluid causing swelling). On-call provider was notified on 04/14/24 at 02:44 AM and no new orders received. On 06/14/24 at 08:40 AM During an Interview with Clinical Care Coordinator (CCC) D Stated they had checked his vitals, a provider came in and checked him, checked his lungs, O2 sat's. Provider went to nurses' station to writer orders, the emergency Medical Service (EMS) walked by the station to pick him up. R11 stated he wasn't feeling well, she called provider came in and assessed him. CCC D stated she did not see a progress note for the provider on 04/14/24. CCC D stated she was standing there with provider during his assessment and the orders given. CCC D stated unfortunately, he did not put in a progress note. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/14/24 at 02:18 PM, CCC D stated she had called the provider regarding the hospital visit with no progress note. CCC D stated R11 had went out to the hospital on 03/25/24 first, and that was the visit that provider stated he saw the resident. Provider looked through his draft notes and he found his note and scanned it in the medical record. 34705 Resident #121(R121) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R121 was a [AGE] year old male admitted to the facility on [DATE], with recent re-admission post new onset diabetes mellitus on 4/4/24 with prior diagnoses that included traumatic brain injury with left craniotomy, pelvic fracture, hypertension (high blood pressure), diabetes insipidus, seizure disorder, hypopituitarism, hypothyroidism, speech and language deficits following brain injury, weakness, difficulties walking and depression. The MDS reflected R121 a BIM (assessment tool) score of 7 which indicated his ability to make daily decisions was severely impaired. The MDS reflected R121 had no behaviors including rejection of care. During a telephone interview on 6/11/24 at 11:59 a.m., R121's father and Durable Power of Attorney (DPOA) Z verified was R121 responsible party. R12's DPOA Z reported concerns that facility did not notify him of changes in R121 care at times. R121's DPOA Z reported on 3/29/24, when R121 was transferred to the hospital R121 DPOA Z had requested R121 be transferred to the hospital on day shift related to change in condition several times. R121 DPOA Z reported he noticed the change in R121 condition during a visit and informed the day shift nurse several times who reported the physician had not returned their call. DPOA Z reported had asked for R121 to be sent to hospital at 3:00 p.m. and did not receive return call from the facility until 11:00 p.m. informing him R121 was being transferred to the hospital. DPOA Z reported was very upset because he had requested R121 be sent around 3:00 p.m. and should not need to wait for physician if he was the responsible party. DPOA Z reported R121 blood sugar was over 900 when he arrived to the hospital which was dangerously high and should have been sent much earlier. DPOA Z reported elevated blood sugar was new for R121 but staff should have recognized that he looked ill on the day shift during his visit and listened when he requested R121 be sent to the hospital several times. Review of the Physician Discharge Summary, dated 9/26/23(43 days after hospital admission 8/15/23), reflected R121 had discharge diagnoses that included hypernatremia, diabetes incipidus, head trauma, intraparenchymal hematoma of brain due to trauma, central hypothyroidism, anemia, mixed origin delirium and traumatic brain injury. Continued review reflected, Hospital Course: [AGE] year mal who was admitted to [named hospital] on 7/31/23 to trauma services .Hyperglycemia and A1c of 5.9[elevated], started on insulin gtt[drip], transitioned to subcutaneous . Review of R121's History and Physical, dated 8/15/23, reflected, Assessment and Plan .Hyperglycemia Hemoglobin A1C 8/11/23 5.9(H) .comment: increased risk for diabetes .Levemir 43 units BID . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility History and Physical, dated 9/27/23, reflected, History of Present Illness: The patient had significant head injuries. The patient was admitted to the prolonged hospitalization , ventilation, PEG tube placement, multi specialty intervention. Later, the patient is stabilized. After stabilizing his condition today on 09/27/2023, the patient desired to be transferred to the subacute rehabilitation .Past Medical History: Including acquired problems in the hospital including status post craniotomy,hypernatremia, hypokalemia, central hypothyroidism, hyperglycemia,thrombocytosis, respiratory failure,status post tracheostomy,craniotomy, multiple surgical intervention, status post EGD with PEG tube placement, head trauma,motor vehicle non-traffic accident injury, traumatic subdural hematoma,occipital skull fracture, thrombosis of superior sagittal sinus, GI bleed,status post PRBC transfusion Review of R121 Nutritional Note, dated 12/28/2023 at 8:03am, reflected, DOCUMENT CHANGES IN DIET, INTAKE AND HYDRATION STATUS,PERTINENT LABS::QUARTERLY:Nutrition Note Ht: 70 Current weight:222.8 # BMI:32 Resident has triggered for significant weight gain X 1 month. Weight increased from 193#. Resident has made tremendous improvements since admission. He came in NPO with tube feeding and then started an oral diet with was upgraded and now he has no tubefeeding and weight has increased. Diet is Regular, regular texture, thin liquids- large portions . Review of the Weight Change Notes, dated 3/8/24, for R121, reflected, March weight is 265# 3/6, resident continues to gain weight. Weight 2/26 260#, 2/20 256.6#, 2/13 251# . Review of the Nutritional Note, dated 3/21/2024 at 10:37am, for R121, reflected, Nutrition followup . Residents oral intakes continue to increase. This morning resident ate100% of breakfast and then told aid that he didn't eat. They knew he did eat and encouraged him to just tell them that he wanted more to eat. He then did ask for more so aid got him more to eat this morning. PM aid reported that he ate dinner and had 2 sloppy joes with bag of chips and did snack during the night. Aid did report that his weight gain is impacting how his clothes are fitting. Will review this again with MD to discuss any changes that could be made to meds. Review of R121 Nutritional note, dated 3/29/2024 at 7:39am, reflected, INTAKE AND HYDRATION STATUS, PERTINENT LABS:: QUARTERLY:Nutrition Note Ht:70 Current weight:265 # BMI: 38 Resident has had 10% weight increase X 1 month and 23% weight gain from 6 months ago. Resident had weight gain from 200-231# Sept to Feb. Resident then had bone flap replaced 2/5 and since that time weight has increased to 265#. Over this past month he is constantly hungry, asking for food, snacking all day resulting in significant weight gain .Discussed this with team and it was also stated that since bone flap replaced his behaviors have changed resulting in more anger and trashing his room . Review of the Provider Notes dated 9/2023 through 3/29/24 with no mention of weight gain mentioned or addressed. Continued review of the Provider notes with no mention of glucose monitoring related to history of documented hyperglycemia. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Progress Notes, dated 3/30/24 at 1:23 a.m., for R121, reflected, Resident had a fall earlier today, noted the resident was sleepy and drowsy during the bedtime med pass, about 9pm resident had a right-side weakness, and activity level was below his baseline. Family members were notified and requested him to be sent out. Resident sent out a few minutes to 11pm. resident was tachycardiac and could not feed himself which he normally does. Dr and on call supervisor were notified. Resident transferred out to [named] Hospital with all the paperwork and documentation relating to ombudsman and bed hold policy.(last documented Nursing Progress Note was dated 3/18/24). Review of the Fall Incident/Accident Report, dated 3/29/24 at 2:20p.m., reflected R121 had an unwitnessed fall in the room and was found by aide laying on floor face down. The report reflected R121 was unable to give description. The reported reflected immediate action that was taken included,Resident was assessed for injuries none were noted, neuros were initiated, DON and family notified. The report appeared incomplete with no documentation under pain, mental status, mobity or predisposing factors were blank. (No evidence that investigation or follow up was provided as requested including neurological assessments.) Review of the Electronic Medical Record(EMR), dated 3/29/24, reflected no evidence of neurological checks as indicated on Fall Report until 8:00p.m. on 3/29/24.(Fall was at 2:20p.m.) Further review of the EMR reflected no evidence pain assessment or vitals signs post fall. Review of the SBAR Communication Form and Progress Notes for Change of condition, dated 3/29/24, reflected nurse had notified physician at 8:00 p.m. of R121 decreased level of consciousness. Review of the Nursing Home to Hospital Transfer Form, dated 3/29/24, reflected R121 report was called to the hospital at 12:00 a.m. and the form was completed by DON B on 4/1/24. Review of the Hospital Discharge Summary, dated 4/4/24, reflected R121 was admitted on [DATE] at 12:22a.m. The summary reflected, Admission Diagnosis DKA (diabetic ketoacidosis) .Hyperosmolar hyperglycemic state .HPI, as per admitting provider .On arrival to the ED, stroke team was called to evaluate the patient . Lab work was remarkable for .glucose (985) .He was treated with 2 L normal saline, given a dos of ceftriaxone and placed on an insulin drip according to the e DKA HHS protocol. He was admitted to the ICU for further treatment and management of AMS [altered mental state] likely from hyperglycemia. Hospital Course: Patient is a [AGE] year-old gentleman with TBI and a resident at a nursing home who comes to the hospital with altered mental status and lethargy. Found to have finding concerning for HHS[hyperosmolar hyperglycemic syndrome]. A1c 9.5. 2 months ago was 5.4. Started on aggressive IV fluids and insulin regimen subcutaneously .New onset diabetes likely due to autoimmune diabetes . Attempts were made to contact all day shift staff and transferring nurse (8 staff members) with no answer and no return calls. During an interview on 6/14/24 at 2:03 PM, Facility Nurse Consultant U verified no physician or provider notes were located that mentioned knowledge of R121 significant weight gain prior to change of condition and transfer to the hospital with blood sugars greater than 900 on 3/29/24. 46954 Resident #15 (R15) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Admission Record reflected R15 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis which included mood disorder, anxiety disorder, diverticulosis (a condition where small pouches form in the walls of the large intestine), chronic respiratory failure, and pain in left shoulder. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/17/24, reflected R15's Brief Interview for Mental Status (BIMS) was scored 15 out of 15, indicating cognitively intact. Review of the same MDS reflected R15 was experiencing pain almost constantly. Review of the Physician Order's revealed R15 was prescribed Oxycodone HCl 5 milligrams (mg) (a opioid containing medication) as needed for pain. The order was activated on 4/18/24. Review of the May Medication Administration record revealed R15 was administered the Oxycodone 5mg two to four times daily. Review of the June Medication Administration record revealed R15 was administered the Oxycodone 5mg two to three times daily. According to the National Center for Biotechnology Information website, opioid drugs affect receptors in the gastrointestinal (GI) tract. These receptors control the contraction of the muscles in the GI tract which leads to a decrease in gastrointestinal motility. Review of a Nurses Note dated 5/25/2024 at 12:32 PM revealed Resident [R15] complaining of constipation. Refused MOM (milk of magnesia). Agreed to take Bisacodyl 5mg (laxative tablet) one tablet today and one tonight. Review of an Alert Note dated 5/26/24 at 12:20 PM revealed R15 had a bowel movement. Review of the Physician's Orders revealed a new order for Senna Plus Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 1 tablet by mouth in the morning for constipation. Review of the Bowel Task revealed R15 did not have bowel movement 5/30/24 through 6/4/24 and 6/6/24 through 6/11/24. Review of the May and June Medication Administration Records revealed that no as needed constipation relief medications were offered, refused or administered to R15. Review of the Progress Notes revealed no indication that R15 was offered and refused the as needed constipation relief medications. In an interview on 06/13/24 05:14 PM, Director of Nursing (DON) B stated that the Bowel Protocol should be initiated after a resident does not have a bowel movement after nine shifts. The nurse would initiate the as needed standing orders and administer according to Physician instructions. If the medications do not provide relief, the physician should be notified. DON B reviewed the medical record and confirmed the absence of bowel movements for R15 and the absence of the constipation relief medication being ordered or offered.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 34705 Based on observation and interview, the facility failed to display current nurse staffing information that was readily accessible for all 135 residents, as well as visitors in the facility, resulting in the likelihood of necessary staffing information not being available to residents and visitors. Findings include: During an observation on 6/11/24 at 11:17 AM, posted staffing was located in a staff only area, behind doors with 2 large stop signs that reflected staff only. The posting was dated 6/10/24 with census 133. During an observation on 6/12/24 at 8:00 AM, posted staffing continued to be posted in staff only area, dated 6/10/24. During an observation on 6/13/24 at 9:45 AM, posted staffing continued to be posted in staff only area dated 6/10/24. During an observation, interview and record review on 6/13/24 at 2:25 PM, Human Resource(HR) Staff Y reported had been in position about one month and was responsible for posting staffing. HR Y reported was instructed to post staffing for previous day for staff review. HR verified printed 6/11/24 and 6/12/24 and posted that day after review of posting observed and verified was staff only area. HR Y reported was not aware staffing posting had to be in public area or current day staffing.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. 27446 Based on interview and record review the facility failed to ensure one out of seven residents (Resident #51) did not receive unnecessary medications. Findings Included: Record review of a progress note dated 2/6/2024 and timed at 8:39 AM, revealed Resident #51 (R51) had an urinalysis (UA) (test of the urine for infection) done which was reviewed by the Physician. The note revealed R51's Physician ordered Cipro (an antibiotic) to be administered to R51 for seven days. The note did not reveal whether R51's UA result was positive or negative for infection. The progress notes did not have any documentation as to why the UA was required to be performed. Another progress note dated 2/6/2024 and timed at 2:29 PM, revealed the Physician had spoken with the nurse about R51 complaining of bladder and flank pain (pain in the side of the back) and was confused. The note revealed the Physician reviewed R51's UA results, and although there was no growth of bacteria (the culture was negative for bacterial growth which indicates an infection), Cipro was to be started due to R51's symptoms. Review of a Physician's order dated 2/6/2024, revealed R51 was to received Cipro for seven days. Review of the UA dated 1/31/2024 for the date collected, 2/2/2024 for the date the laboratory received the urine sample, and 2/5/2024 for the date the results were reported to the facility revealed the urine culture yielded no bacterial growth after 48 hours, and therefore was negative. In an interview on 6/14/2024 at 12:11 PM, Registered Nurse (RN) C, who was the Infection Control Preventionist stated that she had followed up with the Nurse Practitioner twice regarding the Cipro that she ordered for R51, that the Cipro did not meet criteria to be administered. RN C stated that the facility used McGeer criteria (a symptom based list of criteria for the use of antibiotics), and said she asked the Nurse Practitioner to put in a note as to why she thought R51 still needed the antibiotic. RN C said the note the Nurse Practitioner made revealed pain and based on the UA results was the reason. RN C said she had reported to the Medical Director the Nurse Practitioner was writing orders for antibiotics without indications for use.

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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. 34705 Based on observation, interview, and record review the facility failed to ensure a medication error rate less than five percent when 8 medication errors were observed from a total of 28 opportunities for one resident (R121) of eight residents observed during medication administration, resulting in a medication error rate of 28.57%. Findings include: During an observation and interview on 6/13/24 at 7:54 a.m., Licensed Practical Nurse (LPN) R prepared several medications for R121 at the medication cart. LPN R crushed several oral medications including Keppra 750 mg one tablet and Ferrous Sulfate 325 mg one tablet. LPN R crushed eight total medications(keppra, ferrous sulfate, zoloft, metformin, Tamsulosin HCl, Prilosec, Glycopyrrolate and Carbamazepine) and added to orange juice and administered to R121. R121 observed with facial grimacing and shaking head during administration. LPN R reported crushed medications and placed in orange juice because R121 does not like to take medications. Review of the Pharmacy Recommendations Progress Notes, dated 3/5/2024 at 11:06 a.m., for R121, reflected, PHARMACIST RECOMMENDS:: This patient has an order for crushed meds. Keppra and ferrous sulfate are not to be crushed. Please add do not crush to each order OR change each order to oral solution. Review of R121 Physician orders, dated 4/5/24 to current, reflected, Ferrous Sulfate Oral Tablet 325 (65 Fe)MG (Ferrous Sulfate) Give 1 tablet by mouth in the morning for supplement DO NOT CRUSH . levETIRAcetam[Keppra] Oral Tablet 750 MG(Levetiracetam)Give 1 tablet by mouth two times a day for seizure prophylaxis DO NOT CRUSH . Review of the Medication Not To Be Crushed, located inside the narcotic binder on the top of each medication cart, reflected Keppra and Ferrous Sulfate should not be crushed. During an interview on 6/14/24 at 10:38 AM, LPN S reported staff nurses know which medication not to crush because of resource document located in narcotic binder on each medication cart. LPN S verified both Keppra and Ferrous Sulfate were on the document labeled, Medication Not To Be Crushed, dated 7/19. During an interview on 6/14/24 02:05 PM, Nurse consultant U reported verified R121 Keppra and Ferrous Sulfate should not have been crushed and verified order reflected that.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview, and record review the facility failed to insure that one resident (R121) was free from significant medications errors out of eight residents reviewed during medication pass task, resulting in the potential for adverse physical reactions/outcomes to residents. Findings Included: Resident #121(R121) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R121 was a [AGE] year old male admitted to the facility on [DATE], with recent re-admission post new onset diabetes mellitus on 4/4/24 with prior diagnoses that included traumatic brain injury, pelvic fracture, hypertension (high blood pressure), diabetes insipidus, seizure disorder, hypopituitarism, hypothyroidism, other speech and language deficits following brain injury, weakness, difficulty walking and depression. The MDS reflected R121 a BIM (assessment tool) score of 7 which indicated his ability to make daily decisions was severely impaired. The MDS reflected R121 had no behaviors including rejection of care. During an observation and interview on 6/13/24 at 7:54 a.m., Licensed Practical Nurse (LPN) R prepared several medications for R121 at the medication cart. LPN R crushed several oral medications including Keppra 750 mg one tablet and Ferrous Sulfate 325 mg one tablet. LPN R crushed eight total medications(keppra, ferrous sulfate, zoloft, metformin, Tamsulosin HCl, Prilosec, Glycopyrrolate and Carbamazepine) and added to orange juice and administered to R121. R121 observed with facial grimacing and shaking head during administration. LPN R reported crushed medications and placed in orange juice because R121 does not like to take medications. Review of the Pharmacy Recommendations Progress Notes, dated 3/5/2024 at 11:06 a.m., for R121, reflected, PHARMACIST RECOMMENDS:: This patient has an order for crushed meds. Keppra and ferrous sulfate are not to be crushed. Please add do not crush to each order OR change each order to oral solution. Review of R121 Physician orders, dated 4/5/24 to current, reflected, Ferrous Sulfate Oral Tablet 325 (65 Fe)MG (Ferrous Sulfate) Give 1 tablet by mouth in the morning for supplement DO NOT CRUSH . levETIRAcetam[Keppra] Oral Tablet 750 MG(Levetiracetam)Give 1 tablet by mouth two times a day for seizure prophylaxis DO NOT CRUSH . Review of the Medication Not To Be Crushed, located inside the narcotic binder on the top of each medication cart, reflected Keppra and Ferrous Sulfate should not be crushed. During an interview on 6/14/24 at 10:38 AM, LPN S reported staff nurses know which medication not to crush because of resource document located in narcotic binder on each medication cart. LPN S verified both Keppra and Ferrous Sulfate were on the document labeled, Medication Not To Be Crushed, dated 7/19. During an interview on 6/14/24 02:05 PM, Nurse consultant U reported verified R121 Keppra and Ferrous Sulfate should not have been crushed and verified order reflected that.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34705 Based on observation, interview, and record review the facility failed to ensure proper storage of medications for 1 of 3 medication rooms reviewed, resulting in the increased likelihood for decreased medication efficacy and adverse side effects in a current facility census of 135 residents Findings include: During an observation on 6/12/24 at 3:40 PM, Licensed Practical Nurse (LPN) V reported Registered Nurse (RN) W was orienting with her that day unlocked the south hall medication room. LPN V reported medication room had two refrigerators and one was for resident overstock medications and the other was for vaccines. This surveyor opened the closed vaccine refrigerator and LPN V verified the thermometer read 60 degrees. Several single dose flu and pneumonia vaccines and 2 bottles of tuberculin were observed along with an ice pack. LPN V reported the night shift monitored the refrigerator temperatures and was unsure where they were located. LPN V was asked what the refrigerator temperature should be at she pointed to sign on the wall that reflected under 40 degrees. LPN V was observed attempting to locate temp log in medication room and nurse station and was unable to locate. During an interview and record review on 6/12/24 at 2:45 PM, Clinical Care Coordinator (CCC) X reported was responsible for first floor south unit and reported refrigerator temperatures were monitored by night staff and was unsure where they were documented. CCC X asked the Director of Nursing (DON) B who reported the frig temp log was located at the South Nurse Station in binder. DON B located the binder that included one incomplete frig log last documented on 6/11/24 at 41 degrees. DON B reported would expect staff to monitor both refrigerators and document temps daily and verified several missing temps 6/3/24-6/10/24. DON B reported did not locate temp log for vaccine frig and verified temp was too warm and removed vaccines and reported plan to dispose. DON B reported frig temp should be between 36 and 41 degrees and verified was over 50 degrees. Review a typed document temperature log titled, Medication Fridge Temps, dated 6/1/24 through 6/12/24, provided by the DON B on 6/12/24 at 4:24 p.m., reflected temps for one vaccine refrigerator twice daily all under 42 degrees. During an interview on 6/14/24 at 8:51 AM, Registered Nurse Infection Control Nurse(RNIC) C reported facility vaccines were stored in a south hall medication room refrigerator that she observed temps in daily Monday to Friday.(Provided log was completed 6/1/24 through 6/12/24). RNIC C reported provided June log to DON B but did not have prior record past current month because was not aware she needed to keep records and deleted at the end of the month. RNIC C reported had not observed vaccine fridge with elevated temps.