STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235262	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hickory Haven	3310 W Commerce Rd Milford, MI 48380

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to ensure residents personnel clothing was routinely returned to them from laundry for three residents (R39, R57 and R56) and multiple residents who asked to remain anonymous at the resident council meeting. This had the potential to affect all residents who relied on the facility to care for their laundry. Findings include: Resident Council On 3/12/25 at 10:00 AM, a Resident Council meeting was conducted with 10 residents who asked to remain anonymous. The residents were asked about life in the facility and any concerns they might have. Multiple residents expressed issues pertaining to their clothing not being returned to them. One resident reported that laundry is sent out of the facility and many times it does not come back to their room. They noted that the person in charge of laundry had been out for over two months, and they believed that added to the confusion. Another resident reported that they had a special [NAME] football shirt that had never been returned and/or replaced. A third resident reported that several sweaters had not been returned. The resident's indicated that the facility is aware of the issue however, they still do not get their own clothes back. R39 On 3/11/25 at approximately 10:37 AM, R37 was observed lying in bed. The resident was alert and reported that they had entered the facility in February 2025. When asked about concerns at the facility, R39 reported they were missing some clothing items. The resident specifically noted that shirts containing the names and numbers of local football players was missing from their room. An observation of the residents' clothes located in their closet did not have any names or labels on the clothes. R37 reported that they did not have a proper pen to label their clothes and noted if they did have one, it may have been difficult for them to write their own names. A review of R39's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses of type II diabetes and pressure ulcers. The resident had a Brief Interview for Mental Status (BIMS) Score of 14/15 (cognitively intact cognition). *It should be noted that an inventory list could be located in the resident's clinical record. R57 (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/25 at approximately 10:27 AM, R57 was observed lying in bed. The resident was alert and able to answer all questions asked. R57 was asked about life in the facility and reported that they had been a resident for several years. They indicated that they were mostly happy with the care provided with the exception of a delay in turning them as well as missing clothing items. R57 reported that they had several shirts of various colors (blue, purple and red) as well as pajamas provided by family that were never returned. On 3/13/25 at approximately 8:18 AM, an observation and interview were conducted with the Administrator and Laundry Staff D. The interview took place in the Laundry/Storage room. Resident clothes were observed hanging up on hangers. Laundry Staff 'D reported that they had been working at the facility for over [AGE] years and noted that they had been out over the past two months. They further indicated that laundry is always sent out to an outside company. Laundry Staff D indicated that clothing should be labeled, but it's not always and this makes it difficult to return to the right resident. Further, at times laundry does not even come back to the facility and might be lost at the outside laundry company. Laundry Staff D noted that at times they believe Agency staff need to be further educated on resident's laundry and the process at the facility. The Administrator noted that they recognized the problem and attempted to replace clothing when made aware, however they were aware that this did not negate that residents' original clothes should not go missing. 39592 R56 On 3/11/25 at 10:55 AM, R56 was observed lying on their bed. R56 appeared sleepy, and did not answer questions asked. On 3/11/25 at 1:33 PM, R56's Durable Power of Attorney (DPOA) was interviewed by phone and asked about care at the facility. The DPOA explained she had to keep buying R56 clothing and blankets because the facility kept losing R56's belongings in the laundry . on Christmas Day, when she came to visit, R56 was in a facility provided gown and had only a thin blanket on the bed which was under a window and it was very cold that day, she went out to her car to get her emergency blanket to take it back in and put it on R56 . has seen other residents wearing R56's clothes . sometimes other residents clothes are in R56's closet. R56's DPOA was asked if R56's clothing and blankets were labeled with R56's name. The DPOA explained she makes sure all R56's clothing and blankets are labeled. On 3/13/25 at 8:58 AM, Laundry Aide D was interviewed and asked about the laundry process. Laundry Aide M explained they used a local laundry and never have had an issue with them, but felt that agency staff did not understand the facility's laundry system. On 3/13/25 at 9:55 AM, Certified Nursing Assistant (CNA) N was interviewed and asked about the laundry. CNA N explained she was a recent hire at the facility and had to adjust to how the facility did laundry . they put all the personal clothing into one bag and all the commercial stuff like towels and linens into another bag . then the laundry aide will bring back the personal clothes and stock the linen closets. On 3/13/25 at 10:00 AM, observation of R56's clothes in the closet revealed R56's name written in permanent marker on the inside of the neck of their tops. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 10:28 AM, the Administrator was asked about the laundry at the facility. The Administrator explained Laundry Aide D had worked at the facility for years and pretty much knows what clothes belong to which resident, but when Laundry Aide D is not there, sometimes the other staff can not read the name written on the clothing. When asked if they had a label machine for clothing, the Administrator explained they did not. Review of a facility policy titled, Missing Items(s) revised July 2008 read in part, .Residents are entitled to retain and use personal clothing and possessions as space permits . When resident's personal clothing is lost, the facility staff will investigate its location and return the item to the resident or provide written response to the resident about the investigation .

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record reviews the facility failed to ensure all staff, including agency staff could timely identify a resident's code status (R72) in the event of an emergency, failed to ensure the physician orders reflected the resident's wishes regarding their code status for four (R's 72, 51, 56 & 174 of four residents reviewed for code statuses. This deficient practice had the ability to affect all 74 residents residing in the facility at the time of the survey. Findings include: R72 A review of R72's Nursing notes revealed a note dated [DATE] at 7:42 AM, that documented in part . Writer alerted by CNA (Certified Nursing Assistant) @ (at) 4:30am that resident on side of bed writer entered room and resident found at side of bed warm to touch, pale in color resident assisted into bed by nursing staff and assessed by writer very faint pulse Code Blue called and CPR (Cardiopulmonary Resuscitation) initiated @ 4:38am . time of death at 5:08am police on site . This note was documented by Licensed Practical Nurse (LPN) B, who was later identified as an agency nurse (not facility-hired staff, but contracted). Review of the medical record revealed R72 was admitted to the facility on [DATE], with diagnoses that included respiratory failure. On [DATE] at 12:09 PM, a telephone interview was conducted with LPN B. When asked about the noted delay in initiating CPR (Caridopulminary Rescussitation), LPN B explained how they worked for an agency and remember R72, because they had not returned to the facility to work after R72 expired. LPN B stated once they identified R72 with no pulse they went on the computer to find R72's code status and was unable to locate it. LPN B stated they called the Director of Nursing (DON) at home to tell them what was going on and that they were unable to find R72's code status. LPN B stated the DON informed them of a binder located on the unit that contained papers of every resident wishes. LPN B stated they eventually found the binder and found R72's paper located in the binder but the document was unclear and it was a number system that they did not understand. LPN B stated there was one other nurse on duty that came over and reviewed the document and informed LPN B that the number documented for R72 meant that R72 was considered a full code. LPN B stated the code was called and they went to R72's room to initiate CPR. LPN B stated in part . It was so unclear (R72's code status) and that's why I have not gone back yet (to work at the facility) . I will never go back . their (facility) code system is just unclear . A review of R72's physician orders revealed no implementation of R72's code status. Further review of the physician orders noted the following order . Refer to Preferred Treatment Option for Advanced Directives . After review of the electronic medical record, located under the facility's Document tab, a Resident Preferred Treatment Option document was found. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Preferred Treatment Option document noted the resident to be Option of Status 4. This required the reader to go to option Status 4 and read the document that noted . Status 4: The resident is to be hospitalized for any treatments that exceed the nursing home's capabilities and that are necessary to extend life or maintain comfort. Such treatments are to include resuscitation and surgical intervention . At the bottom of the document noted the Physician's signature and writing that noted Full Code . This system did not ensure immediate identification of the residents' code status in an event of an emergency. On [DATE] at 9:22 AM, the Administrator was asked to provide the facility's orientation documentation and check list for all agency staff. A review of the orientation documentation and check list for agency staff provided by the facility's Administrator revealed no documentation or review of the facility's code status system or Preferred Treatment Option for Advance Directives system. This revealed that the agency staff was not trained on where to locate the resident code status and the agency staff was not trained on the facility's Preferred Treatment Option Advance Directives. R51 Review of the clinical record revealed R51 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: hemiplegia (paralysis) affecting left nondominated side, major depressive disorder and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R51 had intact cognition. Review of physician orders revealed an order with a start date of [DATE] that read, Refer to Preferred Treatment Option for Advanced Directives. Further review of the physician orders revealed no implemented order of R51's code status. Review of the Document tab for R51 revealed a document titled, RESIDENT PREFERRED TREATMENT OPTION that was marked with Status 4 and signed [DATE] with a hand written note at the bottom that read, Status 4 - Full Code and signed by the physician. R56 On [DATE] at 10:55 AM, R56 was observed lying on their bed. R56 appeared sleepy, and did not answer questions asked. Review of the clinical record revealed R56 was admitted into the facility on [DATE] with diagnoses that included: dementia, heart failure and anxiety disorder. According to the MDS assessment dated [DATE], R56 had severely impaired cognition. Review of physician orders revealed an order with a start date on [DATE] that read, Refer to Preferred Treatment Option for Advanced Directives. Further review of R56's physician orders revealed no order implemented for the DNR. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Document tab for R56 revealed a document titled, DO NOT RESUSCIATE ORDER EXECUTED BY ATTENDING PHYSICIAN AND DPOA OR GUARDIAN that was signed [DATE]. The tab also revealed a document titled, RESIDENT PREFERRED TREATMENT OPTION that was marked Status 3: The resident is to be hospitalized for any treatments that exceed the nursing home's capabilities and that are necessary to extend life of maintain comfort. Such treatments are not to include resuscitation Surgical intervention is limited to conditions with a high probability of a successful outcome. signed [DATE]. R174 A review of R174's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease. The resident was noted to have a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] (moderately cognitively impaired). There was no indication in the resident's electronic record that noted the resident's code status and additional end of life wishes. During the Survey, the facility had reported that resident's code status would be found in a binder located near the nurse's station. An attempt to locate the binder, including R174's code status and end of life wishes was made on [DATE] at approximately 12:35 PM. Two Certified Nursing Assistants (CNAs) attempted to locate the facility code status binder. They were not able to find it and thought perhaps code status would be found in the resident's closets. At approximately 1:00 PM on [DATE], the DON was asked to locate the binder. The DON did point out where the binder was located. A document titled, Resident Preferred Treatment Option was reviewed and noted the resident was Status 3: The resident is to be hospitalized for any treatments that exceed the nursing home's capacities and that are necessary to extend life or maintain comfort. Such treatments are not to include resuscitation. Surgical intervention is limited to conditions with a high probability of a successful outcome. A second review of R174's electronic record was conducted. Again, no documentation was found. On [DATE] at 1:57 PM, the Administrator and DON was interviewed and informed of the concern regarding the delay of the agency staff not being able to immediately identify R72's code status, informed of the resident's code status to not be located under the facility's physician tab and the concern of the current residents' code status to not be immediately available in an event of an emergency. The Administrator and DON acknowledge the concern, however, the DON asked if the corporate Clinical Support Nurse (CSN) C could join the interview to explain the facility's process. At 2:08 PM, CSN C entered the conference room and stated the facility has a paper copy that is kept in a binder at the nurses station. CSN C stated although the code status order is not located under the physician orders, the physician signs the bottom of the Preferred Treatment Option Advance Directives document and they considered that to be the physician's order. CSN C stated the document should be uploaded in the document tab once signed by the physician. At this time R174's electronic record was then pulled up. The Administrator, DON and CSN C reviewed the documentation under the Documents tab and confirmed that the Resident Preferred Treatment Option was not located in the resident's record and should have been. CSN C stated they understood the concern regarding the agency staff to not be trained on the code status system. CSN C was asked why in the facility's Electronic Medical Record where there was a line that read Code Status: it had a link that read (Advance Directive), but when the link was clicked on, it brought up No Files Found. CSN C explained it would be helpful if the link would actually pull up the document, but they were not able to link it. CSN C also explained they did not want to put the code status in there because they were afraid of someone entering it wrong and providing the wrong information. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Cardiopulmonary Resuscitation (CPR) dated [DATE], revealed no clarification or directive for staff on where to locate, find and identify the residents who requested CPR or DNR (Do Not Resuscitate) status. No further explanation or documentation was provided by the end of the survey. 34275 39592

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to appropriately transfer a resident per their assessed needs for two (R51 and R64) of six residents reviewed for falls. Findings include: R51 On 3/12/25 at 9:43 AM, R51 was observed sitting on the side of the bed. An ankle-foot orthosis (AFO) brace on their left foot was observed. R51 was asked if they had fallen recently. R51 explained as they were transferring from their wheelchair to the toilet, their feet got tangled up because they have a paralyzed foot. R51 was asked how many staff members were present when they were being transferred. R51 explained there was only one. When asked how many staff are usually present when they were being transferred, R51 explained usually there would be only one staff present. Review of the clinical record revealed R51 was admitted into the facility 3/3/22 and readmitted [DATE] with diagnoses that included: hemiplegia (paralysis) affecting left nondominant side, need for assistance with personal care and lack of coordination. According to the Minimum Data Set Assessment (MDS) dated [DATE], R51 had intact cognition, had upper and lower body impairment on one side, and was dependent on staff for transfers. Review of R51's Activities of Daily Living (ADL) care plan revealed an intervention revised 2/28/25 that read, TRANSFER: Two Assist, AFO to left leg when out of bed. Additional review of all R51's revised ADL care plans revealed from the initial care plan dated 3/7/22, R51 was always a two person assist for transfers. Review of R51's progress notes revealed an Interdisciplinary Documentation by Registered Nurse (RN) G dated 3/10/25 at 1:43 PM that read in part, Writer notified of CNA (Certified Nursing Assistant) having to lower resident to the floor due to resident losing her balance during a transfer to the toilet . On 3/12/25 at 10:18 AM, CNA E, an agency CNA, was interviewed and asked how they knew what the transfer status of a resident was. CNA E explained each residents' care plan was posted on the inside of their closet door. On 3/12/25 at 10:26 AM, observation was made of RN G of assisting R51 and a Family Member out of the bathroom and telling R51 she was assisting because R51 was a two person assist. R51 replied in a surprised voice, I am?. On 3/12/25 at 10:97 AM, observation of R51's closet revealed R51's ADL care plan posed in plastic sleeves and read the same, TRANSFER: Two Assist, AFO to left leg when out of bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 10:31 AM, the Therapy Director (TD) was interviewed and asked about R51's transfer status. The TD explained R51 was a two person assist due to their left leg paralysis, and that R51 overestimated their abilities. On 3/12/25 at 10:38 AM, the Director of Nursing (DON) was interviewed and asked about R51's fall. The DON explained she had been told R51 did not want to wait for another staff member, so the CNA just transferred R51 by herself. The DON was asked if it was ever acceptable to transfer a resident assessed as a two person assist with only one person. The DON explained there should always be two people if they are care planned for two people. When asked who the CNA was, the DON explained it was CNA I, who was an agency CNA. Review of CNA I's employment file revealed an Education Acknowledgement signed 8/1/24 that included Care Plans. On 3/13/25 at 10:36 AM, a phone call was made to CNA I and a voice mail was left. No return call was received prior to the end of the survey. 34275 R64 On 3/11/25 at approximately 11:03 AM, R64 was observed sitting in a large activity/dining room with other residents. R64 was alert but not able to answer questions appropriately. A review of the resident clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: cerebral infarction (ischemic stroke). A review of the resident Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 7/15 (severe cognitive impairment). Progress Note (11/13/24): Staff was transferring resident off the toilet to her wheelchair when her foot began to slide from under her . R64's care plan was reviewed and documented, in part: Focus: R64 has altered functional mobility and ADL's (activities of daily living) .Interventions: .Ability to leave on toilet - No (2/1/24) .Bed Mobility: asses of two .Ambulatory: Non-Ambulatory (2/1/24) .Fall Risk Management: Encourage Non-skid Footwear (2/1/24) . 11/13/24 .Resident is to wear shoes during all transfers .Transfer: One Assist, Right AFO (ankle foot orthosis - brace requiring a shoe) on when out of bed .Transfer: .Two Assist (2/1/24) . An Incident/Accident (IA) report provided by the facility was reviewed and documented, in part: Witnessed Fall .Date: 11/13/24 at 2:05 PM .Staff was transferring resident off the toilet to her wheelchair when her feet began to slide from under her .Immediate Action Taken .Shoes placed on residents feet .Notes: R64 is a 2 assist for transfers and as staff were assisting to transfer her form the toilet to w/c (wheelchair) she became weak .At the time of resident occurrence, CNA verbally re-educated on need for non-skid foot protection with for ambulation and .transfers and resident need 2 assist, and required to follow care plan . *It was noted on the IA that the CNA involved in the incident was CNA R. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt to contact CNA R was made via telephone on 3/13/25 at approximately 1:45 PM. No return call was made prior to the end of the Survey. The Survey personnel file noted that the CNA R resigned from the facility on 11/21/24. On 3/13/25 at approximately 2:01 PM, an interview was conducted with the Director of Nursing (DON). When asked about the incident causing R64 to fall to the floor, the DON reported that they did not recall the entire event, however recalled educating CNA R that that R64 was a two person assist.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility to provide adequate care coordination related to hospice services for one Resident (R52) of two residents reviewed for hospice services. Findings include: Review of R52's Minimum Data Set (MDS) assessment, dated 2/14/25, revealed R52 was admitted to the facility on [DATE], with diagnoses including lung disease, alcohol abuse, pressure ulcers, and dementia. The assessment revealed R52 could feed themselves with set-up, and was dependent for toileting, bed mobility (rolling), and transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which showed R52 was cognitively intact. The pain assessment showed R52 had at least moderate pain frequently over the past five-day assessment period, which occasionally interfered with their sleep. The nutritional assessment showed R52 was edentulous, was 61 tall, and weighed 79 pounds upon admission. The assessment showed no behaviors or symptoms of depression. The assessment showed R52 was receiving oxygen, on hospice care, and was receiving opioid pain medication. On 3/11/25 at 11:07 a.m., R52 was laying in their hospital bed, wearing a hospital gown, and was receiving oxygen via a nasal canula. R52 appeared thin and underweight, with protruding bony prominences, and an empty pudding cup container on their bedside table. R52 stated they knew they were pressing their call light frequently. When asked why, they stated, I feel lonely. R52 appeared unsettled and anxious, and said they were uncomfortable. R52 was observed fidgeting with their hands and demonstrated little eye contact. On 3/11/25 at 11:09 a.m., R52 stated, No, it is not going well here. R52 reported they struggled when they had to wait anywhere from 15 minutes to a half hour to receive their pain meds for very high pain in their stomach. R52 reported they could receive their pain medication every two hours, and they needed it to be on time, as they had high pain when the pain medication was wearing off. R52 pushed their soft touch pad call light for pain medication during the interview, as they believed it was due. On 3/11/25 at 11:11 a.m., R52's nurse, Licensed Practical Nurse (LPN) S, an agency nurse, answered their call light. R52 stated they wanted their pain medicine due to high pain. LPN S explained to R52 they were due for their pain medication in 15 minutes. R52 expressed they needed their pain medication now but understood they had to wait and shared with LPN S it was difficult to wait due to excessive pain. R52 looked at the clock, read the time, and said the morphine and Tylenol were due at 11:26 a.m R52 was alert and oriented to herself, place, time, and situation. On 3/11/25 at 11:17 a.m., R52 stated they could not wait a half hour for their pain meds for severe stomach pain. On 3/11/25 at approximately 11:45 a.m., the Director of Nursing (DON) arrived, and was informed of R52's concerns regarding their unmanaged pain and needing more chocolate pudding, which R52 also shared with the DON. The DON reported to this Surveyor that R52 appeared to be receiving the maximal pain medication, as they received morphine every two hours, and they had called the hospice agency due to R52's high pain, who had scheduled their morphine every 3 hours. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R52's physician orders showed their morphine (short acting) was scheduled every four hours, and every two hours prn (as needed) for breakthrough pain. On 3/12/25 at 1:46 p.m., R52's nurse, Registered Nurse (RN) J, was asked for assistance finding R52's hospice care book, to review their hospice plan of care and review the communication notes, per standards of practice and regulatory requirements, as the facility management reporting they used binders for hospice documentation. RN J looked at the unit nurse's station with this Surveyor, and in the Electronic Medical Record (EMR), and did not find the communication notes or current hospice plan of care. A hospice communication book was found in R52's name, with blank green cardstock pages which were not completed. RN J agreed this was not completed, and asked the Unit Manager, RN U, to assist them. RN U looked for another communication book for R52 and agreed it was not on the unit with the other hospice care books. RN U said they would search in other places for the book, but the expectation was R52's hospice communication book would be located there. On 3/12/25 at 1:54 p.m., a second manager, RN C, came to assist to locate R52's hospice binder with care plan and communication documentation. Both managers found the old hospice notes prior to R52 admitting to this facility in the EMR in the documentation section as Referral Notes (not labeled hospice or company name), however both reported they could not locate any current notes showing hospice care and facility coordination from R52's admission to the facility from 2/04/25 to 3/12/25. The expectation per standards of practice for hospice care in the facility per both unit managers was the hospice communication notes would have been on the unit typically, and the plan of care would have been there or in the EMR, so staff could readily access the notes, for care coordination, appropriate interventions, any significant change, and record keeping requirements for hospice care. On 3/12/25 at 2:15 p.m., this Surveyor emailed the Nursing Home Administrator (NHA) to see if they could provide R52's missing hospice documentation, including all hospice visit communication notes, a current care plan, and assessments, from 2/04/25 to the present, 3/12/25. This Surveyor shared with the NHA they remained missing, per review by both unit managers, RN J, and Surveyor. The NHA emailed this Surveyor back they did not have the missing hospice care documentation, and would attempt to locate the documents. They reported they understood the concern. On 3/12/25 at approximately 3:45 p.m., R52's hospice care notes were received, in part, during their current stay, from the NHA. It was noted they did not include any nursing visits beyond 2/21/25, which was shared with the NHA, who reported they would continue to request the remainder of R52's hospice care notes from R52's hospice care provider. Surveyor noted this would be concerning if R52 had not been seen by the hospice nurse since 2/21/25, per the current records. The NHA reported they understood the concern. On 3/12/25 at 4:28 p.m., R52 was observed in their hospital bed, appearing tired, wearing her oxygen via nasal canula. R52 spoke softly, and reported they were not having a good day. When asked why, R52 stated they wanted their pillows adjusted. R52 appeared restless and was fidgeting with their bedding, trying to reach their pillow. R52 pressed their call light and Certified Nurse Aide (CNA) V arrived, and adjusted R52 by pulling them up in bed and adjusting their pillows. An empty chocolate pudding cup was observed on R52's bedside table. This Surveyor asked R52 what would help them to feel calm. R52 stated getting their pain medication on time, getting chocolate pudding whenever they wanted it, and having their call light answered on time would bring them peace and comfort. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at approximately 4:40 p.m., CNA V reported R52 was attention seeking, and doing about anything to get to keep them in their facility room, as they struggled to be alone. CNA V reported R52 sometimes used their bed remote to raise their head of the bed all the way in the air, so they appeared to be almost sliding down when they left the room, to get them to return to their room. CNA V stated they were worried about them falling out of the bed. CNA V explained they had been in their room [ROOM NUMBER] to 30 times already on their day shift, and R52 was on their call light every five to ten minutes. CNA V stated they had other residents to care for and could not sit in R52's room. CNA V reported they were giving R52 pudding constantly and they did not know how to handle these requests, as R52 was not satisfied when they had pudding, and soon after would request pudding again. CNA V asked if anything else could be done, and if this Surveyor had any ideas. CNA V was asked if they had followed up with their nurse or nursing management and stated they had not. Review of R52's nursing hospice note dated 2/21/25 revealed in the narrative section, .SNV (Skilled Nursing Visit). Received patient (R52) lying in the hospital bed, awake and alert. Patient (R52) was yelling out into hallway. 4 people to come (sic) into her room. Patient (R52) appeared agitated/restless throughout visit and spoke with facility nurse manager, who states patient is restless most of the day, constantly asking for pudding cups, but does not eat all her meals . The hospice note showed R52 was using Lorazepam a few times a day as needed, and they recommended Lorazepam to be increased to scheduled twice a day. The note showed R52's medical and behavioral presentation had changed little from 2/21/25, and there were no other hospice notes available. On 3/13/25 at 11:11 a.m., Physician Q (who was familiar with R52) was asked (in person) about R52's ongoing agitation, restlessness, reports of high pain, and psychosocial distress, including self-reported loneliness, as evidenced frequent use of their call light, possible attention seeking behaviors (verses pain), as well as their seeming insatiable appetite for pudding, without reported satiety. Surveyor and Physician Q reviewed the EMR, Egress, the electronic filing system, and the hospice nursing care notes, which still showed the last hospice nursing visit was on 2/21/25. Physician Q was asked to explain the process for care coordination with R52's hospice and facility care team, and documentation expectations. Physician Q reported the expectation was R52 would be seen by a hospice nurse weekly, and the notes should have been available and found in the EMR. Physician Q acknowledged they had not seen any current hospice care notes. Physician Q reported the hospice team should have had their social worker making more recent visits due to R52's ongoing anxiety, restlessness, and agitation, and may have considered involving pastoral (spiritual) services, pending R52's wishes. Physician Q shared they believed the social worker and/or care team should have worked to identify the cause of R52's pervasive anxiety, such as were they afraid of dying, wanting to go home, or other unknown reasons. Physician Q conveyed their expectation would be the most recent, current hospice documentation would be readily available in the EMR, and there should be ongoing communication documented between the hospice providers and the nursing and physician/medical care team in the medical record (which was not currently found with mutual record review). Physician Q reported if they had been made aware of R52's ongoing psychosocial concerns and high anxiety, they may have requested psych services would have been involved in R52's care and planned to follow-up. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the R52's physician orders on 3/13/25 with Physician Q revealed they had concerns regarding R52's medications. Physician Q stated if they had been made aware of R52's high anxiety, they could have potentially prescribed an anxiety medication which was longer acting, such as Clonazepam, to mitigate (mood) peaks and troughs, as they explained their current medication, Lorazepam, was shorter acting, and may have contributed to R52's ongoing reports and observations of anxiety, including their restlessness and behavioral presentation. Physician Q reported they planned to speak with the hospice provider immediately to address R52's medication concerns. Physician Q stated they had a concern if the hospice provider was adjusting the medication and not doing a follow-up, since the recent nursing documentation was unavailable. Physician Q additionally noted new orders were just placed in the EMR during the interview on 3/13/25 by hospice to increase R52's short acting Morphine to every three hours (received from the DON) and reported there were possibly better medication options, such as MS Contin, which was a longer acting morphine, as R52 was currently on Roxanol, which was a shorter acting Morphine. Physician Q reported they would have been expected to have been contacted by the hospice provider and a discussion to have ensued to coordinate R52's medications, as they were frequently in the facility (including on 3/13/25) and oversaw R52's care as their facility physician provider, along with the medical director. Physician Q stated they were both readily available and accessible. Physician Q explained a longer-acting pain medication would help R52 not to be using her call light around the clock to try to get her pain medication exactly two hours later when it was due, which may have been challenging for staff at times. Physician Q reported they had communication concerns with R52's hospice provider. On 3/13/25 at approximately 11:56 a.m., the NHA was asked if they had obtained any additional hospice records, per their earlier report there may have been some missing documents in the first batch of hospice notes received. At 12:02 p.m., the NHA reported they had received some additional hospice notes a few minutes prior and were placing them into Egress, the State facility shared electronic filing system. On 3/13/25 at 12:05 p.m., review of the Egress Electronic filing system showed additional hospice visit notes for R52 were uploaded, including nursing visits notes after 2/21/25. On 3/13/25 at 12:10 p.m., the NHA was asked why the hospice notes were not readily available for facility staff to have access and available to review for a resident (R52) currently on hospice care. The NHA reported their health information manager no longer worked at the facility, and they wondered if the records had gone to their email and had not been printed. The NHA stated, This is a process we are going to have to get better at ., and reported they understood the concern. The NHA was asked if they had a policy respective to documentation filing and availability, given these concerns. The NHA reported they did not have a policy related to this. A hospice policy was provided, upon request, but did not include documentation expectations. On 3/13/25 at 12:20 p.m., Physician Q followed up with this Surveyor, and showed this Surveyor R52's new orders they had just received from the DON, which included a psych consult (for psychosocial concerns), and MS Contin was ordered yet the short acting Roxanol remained in place. Physician Q' reported they planned to follow up with the hospice provider regarding the new orders, as they had some concerns and planned to provide hospice care coordination before approving the orders, as they were reviewing the pain medication orders further. Physician Q was made aware of the missing hospice nursing notes newly available by the NHA, which showed nursing visits had occurred after 2/21/25. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 12:38 p.m., the DON asked to meet with this Surveyor, and reviewed the newly received hospice nursing notes and the new physician orders, as described by Physician Q. The DON provided notes which showed the newly available hospice nursing notes, which showed the hospice nurse saw R52 on: 3/07/25, 2/28/25, 2/21/25, and prior, and their visit was due this week. This Surveyor asked the DON about the records not being available in the facility for their staff. The DON reported they understood the concern related to documentation being unavailable, per the NHA's description. The DON clarified they understood the concern related to the need for improved hospice care coordination and updated interventions with the facility, respective to R52's ongoing agitation, restlessness, pain, and behavioral concerns. On 3/13/25 at 1:25 p.m., R52's hospice nurse, Registered Nurse (RN) W, was asked about their hospice care coordination with the facility during a phone interview, respective to R52's ongoing concerns related to restlessness, agitation, pain, behavioral presentation, psychosocial needs, and decreased satiety. RN W reported the disconnect on the notes may have been R52 was transferred to the current facility from another skilled care facility, and there may have been a delay in facility receipt due to this process. RN W reported they completed their notes timely and submitted them to their hospice provider, and could not speak to that process, i.e. what happened after they completed their electronic documentation. RN W clarified they logged their visits by hand on a green log form in a hospice binder in the facility, and were unclear why this was not found during the survey for R52. RN W explained they were only at the facility once a week, and since R52's anxiety medication had been increased, they had not been made aware by facility staff of R52's symptoms of anxiety including restlessness and agitation remained an ongoing concern. RN W reported they had been made aware of medication changes and typically with palliative medication changes, they went through the hospice physician and did not communicate with R52's in house physician team, including Physician Q and or the facility Medical Director, per their hospice process. Review of the policy, Hospice Care, revised June 2018, revealed, It is the policy of this facility to screen terminally residents who may be eligible for Hospice Benefit and provide the resident and / or authorized representative with options for these services. Purpose: To support the family and resident and provide the Interdisciplinary Team with additional expertise in pain management, symptom control and bereavement assistance when determined reasonable and necessary .Procedure: 1. Pursuant to regulations, hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions .2. Hospice is responsible for providing hospice services. The nursing facility provide room and board and care unrelated to the terminal illness. 3. The process of delivering palliative services continues within the dual regulations of the Nursing Facility and Hospice. 4. The Care Plan will reflect the hospice philosophy and be based on an assessment of the resident's needs and specific living arrangements within the nursing home. 5. The plan of care will reflect the residents' current medical, physical, psychosocial, and spiritual needs .a. Hospice will reflect these coordinated services on the facilities template for the plan of care within the medical record. b. The plan of care will reflect which services are provided by the nursing facility and which are provided by hospice. c. The facility and hospice (provider) are responsible for performing their respective functions, which have been agreed upon and included in the jointly developed Plan of Care .7. During the provision of hospice services, the attending physician remains in charge . (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility and provider hospice contract, signed 2/04/25, revealed on Page 12: 4.2.4. Facility shall promptly inform Hospice of any change in the condition of a Patient. This includes, without limitation, a significant change in a Patient's physical, mental, social, or emotional status, (and/or) clinical complications that suggest a need to alter the Plan of Care .4.3: Mutual responsibilities. Hospice and Facility shall communicate with one another regularly and as needed for each particular patient. Each Party is responsible for documenting such communication in its respective clinical records to ensure that the needs of patients are met 24 hours a day. Hospice shall periodically review with the facility representative to verify that Hospice supplied Facility with a copy of each Patient's (Hospice) Plan of Care .