STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235264	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ely Manor	1200 Ely St Allegan, MI 49010

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41424 This citation pertains to Intake: MI00148829, MI00147804, MI00148226 and MI00148227. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from staff to resident and resident to resident verbal and physical abuse for 4 (Resident #107, #101, #102, and #104) of 11 residents reviewed for abuse, resulting in the potential for physical, emotional and psychosocial harm. Findings include: Resident #107: Review of an Admission Record revealed Resident #107 was a female with pertinent diagnoses which included Parkinson's disease, hallucinations, and mild intellectual disabilities. Review of Care Plan for Resident #107, revised on 9/3/24, revealed the focus, .(Resident #107) has impaired communication r/t (related to) as evidenced by my primary language is Spanish. I am fluent in English . with the intervention .Encourage resident to continue stating thoughts even if resident is having difficulty . Observed for non-verbal indicators of attempts to express self, such as, tears, furrowing of the brow, pursing of lips, yelling, grabbing, reaching, gestures .allow adequate time to respond, repeat as necessary, face when speaking and make eye contact .when giving directions, give simple 1-2 step commands as needed . Review of Care Plan for Resident #107, revised on 9/3/24, revealed the focus, .(Resident #107) is at risk for adverse reactions and side effects r/t receiving psychotropic medication. Resident takes antipsychotics r/t (related to) Parkinson's hallucinations, which have historically caused significant distress. My hallucinations often involve seeing dead humans, I may experience trauma from my hallucinations . with the interventions . Offer non-pharmacological interventions: 1)Calm, quiet, approach .2)Offer food/drink .3)Offer activity . 4)Assess pain, offer tx (treatment) as indicated .5)Offer rest .6)Offer bathroom .7)Reposition .8)Redirect to quiet area .9)Approach 1:1 if possible .10)Approach by different care giver .11)Maintain ambulation/offer w/c ride .13)Provide reassurance .Report to nurse s/sx (signs/symptoms) of following: confusion, mood change, change in normal behavior, hallucinations/delusions, shuffle gait, balance probs, movement probs . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Investigation submitted to the State Agency dated 12/2/24, revealed, .On December 2, 2024, staff member, (Scheduler E) reported to the Administrator that she overheard (Certified Nursing Assistant (CNA), F), swearing at a resident, (Resident #107) .Interviews/Investigation: (Scheduler E) - Scheduler - (Scheduler E) states she heard (Certified Nursing Assistant (CNA), F) say Stop f*&^%$g scratching me, she then observed (Certified Nursing Assistant (CNA), F) pushing (Resident #107) in her wheelchair out of her room during which (Resident #107) had her legs down, no foot pedals, attempting to stop the wheelchair from moving forward. (Scheduler E) states (Resident #107) was not wanting to leave her room. (Scheduler E) states she went to the administrator immediately .(CNA F) - Certified Nurse Aide - stated that she was having difficulty redirecting (Resident #107). (CNA F) explains that (CNA H) was in the room with (Resident #107) who was being behavioral and was difficult to redirect. (CNA F) said she passed by the room and noticed that (CNA H) needed assistance with (Resident #107), she explains that (Resident #107) was at risk for falling so she assisted her into her wheelchair and out to the dayroom because she didn't want her to be alone in her room and fall. When (CNA F) was asked if she cursed at the resident she states, I don't know, not that I remember. The Administrator asked (CNA F) if (Resident #107) was refusing to go to her wheelchair and out of her room, she replied with what are we supposed to do? Even if they are at risk of falling we can't take her out of her room. (CNA F) admits that (Resident #107) did not want to exit her room. (CNA F) was unable to give any further information to the incident and simply stated I thought she was going to fall and I was doing the right thing .Conclusion: After investigation and interview with the facility staff the incident is believed to be substantiated . Review of Psychiatry Follow-Up dated 12/3/24, revealed, .Her thought process is disorganized at times .A review of systems is not reliably obtained due to her condition .The patient has been managed for Parkinson's disease, dementia, and psychotic disorder with hallucinations .BIMS score of 2, indicating severe cognitive impairment .Mental Status Evaluation .Judgment: Impaired .Insight: Impaired .Thought Process: Disorganized at times .Recent memory is impaired . Review of Social Services Note dated 12/4/24 at 11:52 AM, revealed, .SW did attempt to ask (Resident #107) about the previous incident that occurred but when asked (Resident #107) did not seem to demonstrate any recollection of the incident or what had occurred the last previous couple of days. (Resident #107) did not recall events of this morning or what she ate for breakfast. Staff will continue to monitor and document (Resident #107)'s mood and behaviors . Review of Behavioral Monitoring dated 12/1/24-12/7/24, revealed, .12/1/24 at 11:50: NA (not applicable); 12/2/24 at 02:18 AM, 3:17 PM, 10:48 PM- all NA; 12/3/24 at 5:59 PM, 10:09 PM-both NA; 12/4/24 at 1:21 PM-NA, 12/4/24 at 8:12 PM--7: wandering, intervention effective; 12/5/24 at 2:13 PM--9:Threatening, intervention not effective . In an interview on 1/22/25 at 12:20 PM, Activities Aide (AA) G reported she was in another resident's room when she heard a commotion. It was coming from Resident #107's room. AA G reported she observed the CNA (CNA F) cussing at Resident #107, she had called her a b*%$# and other swear words. The CNA (CNA F) was forcibly pushing Resident #107 down the hallway in her wheelchair all the way from Resident #107's room to the dayroom. AA G reported Resident #107 was placing her feet on the ground trying to stop her from pushing her and grabbing the wheels on her wheelchair to stop CNA F from pushing her and this happened all the way to the dayroom. AA G reported Resident #107 did not want to go to leave her room. AA G reported she and Scheduler E did check on Resident #107 to make sure she was not hurt. AA G reported Scheduler E indicated she was going to report the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/22/25 at 1:28 PM, Scheduler E reported she was assisting a resident a couple of rooms down and she leaned into the hallway from the doorway in the room she was in, when she heard cussing and commotion happening, wondering why someone was cussing that loud, saying Stop f*&^%$g scratching me. CNA F was pulling her out of her room and reported Resident #107 had scratched her and was being behavioral. Scheduler E reported CNA F kept pushing her out of her room and down the hallway. Resident #107 was trying to stop her and there was a lot of resistance, pushing her with no foot pedals, and Resident #107's knees bending in as she tried to stop CNA F from pushing her down the hallway. Scheduler E' reported she told CNA F she needed to stop, that she could not force her out of her room, and push her down to the day room against her will. Scheduler E reported CNA F was holding her arm, cussing that Resident #107 was scratching her, and she continued to cuss after that. Scheduler E went to the Administrator and reported what had happened while AA G stayed on the unit. In an interview on 1/23/25 at 3:04 PM, CNA H reported Resident #107 was messing with her roommate's oxygen and equipment and walking around her room. CNA H reported she was not supposed to walk, as she was unsteady and had fallen before. CNA H reported she had asked Resident #107 to leave her roommate's items alone and to sit down as she was not supposed to be walking. CNA H reported she attempted to redirect Resident #107 several times. CNA F stopped by as Resident #107 was walking around and we were attempting to get her to sit down. Resident #107 stumbled and CNA H was behind her and Resident #107 turned around and was really mad. Resident #107 scratched CNA F and CNA F started to swear, CNA F was behind her and she sat down in the wheelchair, CNA F grabbed the wheelchair and took her into the hallway. CNA H reported she had stayed in the room to pick up the room. CNA H reported she did not see how CNA F got the resident into the wheelchair as she was not paying attention. CNA H reported we were just trying to protect her from falling so she didn't get hurt. In an interview on 1/24/25 at 11:09 AM, CNA F reported on that Monday, (12/2/24) after lunch the staff were bringing resident's back to their rooms. CNA H was in Resident #107's room and she was walking around her room, and getting into her roommate's things. CNA H was attempting to get her to stop getting into her roommate's things and to sit down because she was unstable while she walked. CNA F reported CNA H needed assistance with Resident #107. CNA F reported they were following her around in her room stopping her from getting into her roommate's items and being close as she was unstable. CNA F reported we kept asking her to sit on her bed or in her wheelchair and she wouldn't, she was going to fall. CNA F reported Resident #107 got her fingernails dug into my fingers and in my fingernails, under the nail bed, and deep in my skin. CNA F reported she did scream and swore because it hurt a lot and caught me off guard how bad it hurt. CNA F reported while that was happening, we were still trying to redirect her and get her to sit down. We were going in circles and when we were over by the bathroom door she almost fell , and CNA F was able to get her in the wheelchair. CNA F reported they were just trying to get her to sit down so she was safe. CNA F reported CNA H stayed behind to clean up the room and for Resident #107's safety brought her down to the day room, so someone always had eyes on her, and she could let her cool down a minute as she was angry. CNA F reported she did push Resident #107 down to the dayroom without foot pedals but she was just trying to get her down the hallway. CNA F reported she shouldn't have sworn but it just came out and stunned Resident #107. Using the reasonable person concept, though Resident #107 had decreased ability to verbally express her own thoughts due to her cognitive deficits, she clearly experienced emotional distress following the abuse that occurred on 12/2/24. This emotional distress has the potential to continue well past the date of the incident based on the reasonable person concept. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #101 & Resident #102 Review of an Admission Record revealed Resident #101 was a female with pertinent diagnoses which included Alzheimer's disease, impulsiveness, chronic pain, psychosis, and stroke. Review of an Admission Record revealed Resident #102 was a female with pertinent diagnoses which included intellectual disabilities, bipolar disorder, anxiety, schizoaffective disorder (combination of symptoms of schizophrenia (serious mental illness that affects how one thinks, thoughts or experiences that seem out of touch with reality, disorganized speech or behavior, decreased participation in daily activities) and mood disorder), and restlessness and agitation. Review of Progress Note dated 10/19/24 at 2:11 PM, revealed, .Reported to this nurse by CENA (CNA). Resident (Resident #101) was noted to be behind resident, both in w/c (wheelchair), and (Resident #101) hit (Resident #102) in the back of her head with her hand. (Resident #102) reached behind her head/back and took a swing but did not make any contact with (Resident #101). Both residents were then immediately separated without further concern . Review of Incident Report dated 10/21/24, revealed, .Incident Summary Resident (Resident #101) made physical contact with another resident (Resident #102) .10/19/24 at 2:23 PM . Review of facility investigation dated 10/21/24, revealed, .On October 21, 2024, a member of the clinical staff was reviewing progress notes of a resident and discovered a progress note that stated a resident had physical contact with another resident .Interviews/Investigation: MDS Coordinator, (MDS R) was reviewing resident charts when she came across a progress note written by agency nurse (Licensed Practical Nurse Q) LPN. The progress note was dated 10/19/2024 at 14:23 (2:23 PM), the progress note stated the resident had a physical altercation with another resident. The altercation was not reported to management or the Administrator on 10/19/2024. The MDS Coordinator notified the Administrator as soon as she read the progress note on 10/21/2024. The incident was reported to the State of Michigan and all appropriate parties were notified. Interviews and an investigation were initiated .(Housekeeper S) - Housekeeper - was in the hallway and witnessed the incident.(Housekeeper S) states (Resident #102) was attempting to exit the day room and (Resident #101) came up behind her and smack her in the back of the head with an open hand . (Housekeeper S) states (Resident #102) attempted to hit (Resident #101) back however she was unable to reach her. (Housekeeper S) stated she ensured the residents were unable to make further contact and reported the incident to the primary nurse .(LPN Q) - Agency LPN - Stated she did not believe there was any intent to cause harm, since the resident (Resident #101) was not acting at her baseline and was being treated for a Urinary Tract Infection .Immediate Intervention: The residents were immediately separated and assessed for injury after the incident. Once the Administrator was informed of the incident on 10/21/2024, it was reported to the State Agency .Conclusion: After investigation and interview with the facility staff, the incident of physical abuse was substantiated due to the observation of physical contact between two residents . *Note: No intervention noted to ensure the safety of the residents and other residents on the unit. Review of the medical record revealed Resident #101's care plan was not updated with an intervention following this incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/23/25 at 3:12 PM, Housekeeper S reported she was in Resident #102's room cleaning the room, stepped out of the room, and she heard the slaps. Housekeeper S reported she observed Resident #101 drawing her hand back from Resident #102. Housekeeper S reported CNA F was taking them apart. Housekeeper S reported Resident #102 was very angry and crying hard. In an interview on 1/24/25 at 10:56 AM, LPN Q reported she had worked at the facility a few months and she did not get a formal orientation. LPN Q did report she would complete yearly educations at the facilities she worked at and would provide those educations to the agency. LPN Q reported suspected abuse would need to be reported right away to the abuse coordinator as the facility had two hours to report to the state agency. LPN Q was unable to recall the incident. Review of Encounter dated 11/2/2024 at 00:00, revealed, .Visit Type: Telehealth - Asynchronous Resident was hit by another resident with a closed fist in the face. There is an area of redness on her face, but no other signs of injury, rounding team notified . Review of an Admission Record revealed Resident #102 was a female with pertinent diagnoses which included intellectual disabilities, bipolar disorder, anxiety, schizoaffective disorder (combination of symptoms of schizophrenia (serious mental illness that affects how one thinks, thoughts or experiences that seem out of touch with reality, disorganized speech or behavior, decreased participation in daily activities) and mood disorder), and restlessness and agitation. Review of facility investigation dated 11/2/24, revealed, .On November 2, 2024, at approximately 1:15 PM, a certified nurse assistant witnessed (Resident #102) strike (Resident #101) in the face with a closed hand . Immediate Intervention: The residents were immediately separated and assessed for injury after the incident . (CNA J) - Certified Nurse Assistant states she walked out of another resident's room about the same time she heard (Resident #101) yell ouch, as (CNA J) looked up she observed (Resident #102) 's arm in the air as she was withdrawing her arm back from striking Fern. (CNA J) states she was able to separate the resident ' s before anymore contact was made. (CNA J) reported the incident to the primary nurse and redirected the residents .(Licensed Practical Nurse (LPN) I) - Primary Nurse states she was notified by the CNA that she witnessed (Resident #102) strike (Resident #101) while in the hallway. (LPN I) states she assessed both residents for injury, none observed, and contacted appropriate parties about the incident. During the investigation/interviewing process, (LPN I) states, directly after meal times can be an issue for (Resident #102) as she may experience other residents commuting to and from the dining room and can be upset about other resident's being in the same area as her. (LPN I) communicated with the staff on duty that (Resident #102) would benefit from activities directly after meals as an intervention for (Resident #102) .(Unit Manager (UM) D) - Unit Manager states (Resident #102) can be behavioral at times, especially if she is not able to do what she wants the second she wants to do it, for example if she wants to go for a walk and you tell her you will be back in 5 minutes she will stomp her feet and cry, sometimes she will cuss at you as well. I (UM D) understand she is difficult to understand at times as well and the staff try their best to understand her needs . In an interview on 1/22/25 at 12:39 PM, AA G reported that (Resident #102) had a bad day yesterday, she tried to throw hot coffee on another resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/24/25 at 10:37 AM, LPN I reported when she worked the memory care unit, she always had a hard time with (Resident #102) as she was very aggressive, difficult to redirect, and she would keep Resident #102 with her. LPN I reported there were times she had to assign staff to provide one on one supervision of her as she could be aggressive with everyone. LPN I reported (Resident #102) could be talking to people one minute and then the next hitting and name calling. LPN I reported when she worked the floor she would keep eyes on her even when she was happy as it could switch with a drop of a hat for her. LPN I reported she worked on the weekends from 6AM - 6PM and was typically memory care unit/rehab unit. LPN I reported the staffing for CNAs would typically be a 6 CNAs or 8 CNAs for the building. LPN I reported having activities on the memory car unit was hit or miss hence the reasons when she worked on the memory care unit she would attach herself with Resident #102. LPN I' reported sometimes the had to pull people to stay with her. LPN I' reported as long as someone was sitting in her room reading and interacting, she was fine and happy and then the next moment. During an observation on 1/23/25 at 12:40 PM to 1:47 PM, observed in the day room on the memory care unit there was not an activities aide on the unit and no one supervising in the day room. Activities Aide (AA) HH was observed walking around out in the main area but there was no activity aide. In an interview on 1/23/25 at 1:31 PM, Resident #102 was not in her room, she was in the dayroom in her wheelchair, she was tearful a little earlier, and was attempting to self-ambulate out the other side of the day room door. She had said something unintelligible to me and then she blew a raspberry at me, turned and went back into the day room, no activity person was on the unit at this time. During an observation on 1/23/25 at 1:34 PM, Resident #102 was pointing her finger at another resident at the table she was facing and talking meanly to her while pointing her finger at her. Resident #102 was lowering her head to her hand, she was mumbling something, and then was shaking her right hand. During an observation on 1/23/25 at 3:31 PM, observed no AA staff or nursing staff in the day room for the memory care unit. Resident #102 was seated in her wheelchair by the other side of the table by the living room chair along the far right wall where other residents were seated. She was drinking hot chocolate. During an observation on 1/24/25 at 9:20 AM, Resident #102 was asking to go for a walk and AA K told her that she had to pass out the chronicles, read them and then exercise. CNA M entered the day room and was prompting another resident to eat her breakfast and assisted with her starting to eat and then proceeded out of the day room. assisted another resident . During an observation on 1/24/25 at 9:56 AM, AA K not in the day room she was observed off the unit on the rehabilitation hallway. Resident #101 & Resident #104: Review of an Admission Record revealed, Resident #104 was a female with pertinent diagnoses which included anxiety, restlessness and agitation, cognitive communication deficit, mood disorder, and severe intellectual disabilities. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Care Plan for Resident #104, revised on 9/25/24 revealed the focus, .I have severe impaired cognition function or impaired thought processes r/t (related to) developmental disability .I may yell out at times to express my needs. I will also increase my yelling and sometimes cry when I want attention .Patient is able to communicate verbally and nonverbally using hands, and gestures . with the intervention .6/1/24: OBRA recommendations for recreational therapy staff to provide regular one to one visits .6/1/24: Monitor patient in common areas, and redirect out of crowded spaces patient may become upset trying to maneuver out of crowded spaces .7/6/23: Place my side table in the day room, away from the doorway as I will allow to reduce the risk of other residents unknowingly entering my personal space as I tend to dislike others close to me .11/11/24: Seat me independently at a table or out of reach from other residents during activities as I will allow . Review of Nurses Notes dated 11/3/2024 at 5:34 PM, revealed, .pt (patient (Resident #101)) entered the day room and came up to the table while an activity was going on , pt noted a colored puff ball on the floor, pt bend over to pick it up and another pt sitting at the table yelled as she got to close to her feet, pt then started to swing her right closed hand and made hit the other pt on the left hand . Review of facility investigation dated 11/3/24, revealed, .On November 03, 2024 at approximately 4:30 PM an activity aide observed resident (Resident #101) hit (Resident #104) on her left hand. Immediate Intervention: Residents were immediately separated and assesses for injury .Investigation/Interviews: (Activities Aide (AA) K) - Activities Aide states she was in the dayroom, assisting several residents with a craft activity when (Resident #101) self-propelled into the day room and attempted to assist (Resident #104) with picking up a cotton like ball off the floor. (AA K) states (Resident #101) was picking up the cotton ball off the floor and (Resident #104) began to yell out. (AA K) attempted to intervene however was unable to make it across the room prior to (Resident #101) hitting (Resident #104) on top of her left hand. (AA K) states (Resident #101) was trying to assist (Resident #104) however she was unable to understand what (Resident #101) was doing and began to yell out, once (Resident #104) started to yell (Resident #101) hit her on her left hand to stop her from yelling. (AA K) states she simply was not fast enough to get to the residents before the physical altercation and she has no warning prior too that it would occur .(Licensed Practical Nurse (LPN) I) - Primary Nurse states she was notified of the physical contact between the two residents by the activities aide. (LPN I) states she assessed both residents for injuries, none observed and contacted appropriate parties. (LPN I) states she provided education to the activities aide that (Resident #104) should be seated at a table independently or within arm's reach from other residents as she will allow .Intervention: (Resident #104) should be seated independently or out of reach from other residents while engaging in activities in the day room as she will allow .Conclusion: After investigation and interview with the facility staff, the incident of physical abuse was substantiated . During an observation on 1/23/25 at 9:08 AM, Resident #104 was outside of her room in the hallway along the wall in her wheelchair, and she self ambulated into the dining room. At 9:09 AM, began to yell and she was pointing to the male residents sitting at a table along the wall on the right side, she ambulated to the big table in front of the tv. At 9:16 AM, Resident #104 became expressed sadness and was tearful. Resident #104 then proceeded to self ambulate towards the door area but was looking at the male resident who was at the activity area looking at items in a cautious, agitated expression. During an observation on 1/23/25 at 12:55 PM, Resident #104 was observed in the day room and there were no staff in the day room with the handful of residents who were in there. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/23/25 at 3:31 PM, observed no activities staff or nursing staff in the day room for the memory care unit. Resident #104 was in the dayroom. Resident #104 was seated at the larger table in front of the tv with other residents. During an observation on 1/23/25 at 12:40 PM to 1:47 PM, this writer observed there was not an activities aide on the unit and no one supervising in the day room. There was a puzzle on the large table another resident was working on and Resident #104 was seated at the table with him within arms reach. In an interview on 1/23/25 at 8:33 AM, AA K reported the incident happened when we were in the dayroom on the memory care unit, (Resident #101) came up and said Hello as we were doing an activity and then she heard them arguing and go to break it up and (Resident #101) reaches up and just hits (Resident #104), happened quite fast. She had hit her in the shoulder, neck, and face area. AA K reported she separated them and reported the incident to the nurse, and she proceeded to keep an eye on the two of them. In an interview on 1/23/25 at 8:40 AM, AA K reported we do work between the memory care unit and the other units during the day. We try to make we work in her but when we were short staffed we work the whole building. AA K reported typically there were supposed to be three AAs, with two one day a week, but we can be down due to life events. AA K reported every other weekend she would work and there would be only two of us. AA K reported the AA shifts were 8:00 AM -4:30 PM, and 10:00 AM to 6:30 PM. AA K reported we don't have staff in the facility after that time as most residents don't want to do activities and were going to bed. In an interview on 1/24/25 at 11:09 AM, CNA F reported the activity department was cut at one time, the facility did not have any activity aides. The staff on the memory care unit had been asking for an activities aides on the unit due to so many resident to resident incidents. The facility started to have AA's on the unit but they were not always on the unit and residents weren't being supervised because the CNAs were busy completing cares for residents. In an interview on 1/24/25 at 2:20 PM, Activities Director (AD) P reported the Activity Aides had access to the Kardex (quick access organized resident specific information) in the care plan button. AD P reported she re-educated AAs and they knew where it (the kardex) was located. AD P reported going forward, they would be able to access the resident specific interventions for behaviors and moods. AD P did report the AAs have access to the same system the CNAs have access to. AD P reported the department was so busy and they worked well together to implement the activities in the building. AD P reported she does have a daily huddle with her staff to discuss changes and inform about residents. In an interview on 1/24/25 at 10:37 AM, LPN I reported when Resident #101 was with other residents you had to be observant with her as she could be aggressive with them. If Resident #101 had something that was bothering her, or if she felt like she needed to defend herself, her demeanor could become aggressive, if there was talking which was too loud or bugging her, she would get highly stimulated, and yell for them to shut up. LPN I reported she was not initially aggressive. LPN I reported Resident #104's behavior was she typically reacted with loud vocalizations but not so aggressive out of all of the residents who have behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/24/25 at 1:19 PM, AA K reported if they observed an incident of abuse she would intervene, separate the residents, ensure their safety, notify the nurse and and her immediate supervisor, and would go to Administrator as well. In an interview on 1/24/25 at 1:23 PM, CNA M reported she would intervene as quickly as she saw an incident, separate the residents or resident/staff, ensure the safety and would report to the nurse and Administrator A. CNA M reported she would report it immediately as the facility had two hours to report it to the state agency. In an interview on 1/24/25 at 1:31 PM, Assistant Director of Nursing (ADON) C reported if she saw abuse she would intervene, make sure they were safe, separate them and call the abuse coordinator. ADON C reported she would report it immediately. In an interview on 1/28/25 at 12:00 PM, Director of Nursing (DON) B reported abuse or potential abuse was expected to be reported immediately to the abuse coordinator (Administrator A) or to her, if the abuse coordinator was not present in the building. In an interview on 1/28/25 at 11:40 AM, Unit Manger (UM) D when there was a possible reportable incident, it would be reported to Administrator A, perform a full skin assessment, range of motion for falls, complete the incident report, notify responsible parties, and inform the NP/MD as well. UM D reported would enter a progress note in the medical record, implement an immediate intervention appropriate for the situation. UM D reported would reach out to Administrator A. In an interview on 1/28/25 at 12:29 AM, Administrator A reported she believed the number of resident and resident incidents were due to a combination of things such as those residents who were repeat offenders, new staff members who were learning how each resident was, not having consistent staff on the memory care unit. Administrator A reported the facility had done some shifting on staff and was placing an activities office in the memory care unit which should help with the supervision of the residents and hopefully reduce the number of behavioral situations in the facility. Administrator A reported the facility had activities staff in the memory care unit to implement daily activities for the residents but had lost some activities staff for the department. Administrator A reported the interdisciplinary team was discussing where to place those residents with frequent behaviors, once the doors to the memory care unit was opened, to be able to stay on top of the residents and hopefully prevent further resident to resident incidents. Review of policy, Abuse Prevention revised on 9/9/2022, revealed, .Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41424 This citation pertains to Intake: MI00147804 Based on interview and record review, the facility failed to ensure staff fully implemented the abuse policy for reporting an incident of abuse to the abuse coordinator in 2 out of 13 sampled residents (Resident #101, and #102) reviewed for abuse reporting, resulting in the potential for incidents of abuse going undetected, unreported, or without thorough investigation. Findings include: Resident #101: Review of an Admission Record revealed Resident #101 was a female with pertinent diagnoses which included Alzheimer's disease, chronic fatigue, diabetes, impulsiveness, chronic pain, psychosis, COPD, and stroke. Resident #102: Review of an Admission Record revealed Resident #102 was a female with pertinent diagnoses which included intellectual disabilities, bipolar disorder, anxiety, schizoaffective disorder (combination of symptoms of schizophrenia (serious mental illness that affects how one thinks, thoughts or experiences that seem out of touch with reality, disorganized speech or behavior, decreased participation in daily activities) and mood disorder), and restlessness and agitation. Review of Incident Report dated 10/21/24, revealed, .Incident Summary Resident (R101) made physical contact with another resident (R102) .10/19/24 at 2:23 PM . Review of facility investigation dated 10/21/24, revealed, .On October 21, 2024, a member of the clinical staff was reviewing progress notes of a resident and discovered a progress note tha stated a resident had physical contact with another resident .Interviews/Investigation: MDS Coordinator, (MDS R) was reviewing resident charts when she came across a progress note written by agency nurse (Licensed Practical Nurse Q) LPN. The progress note was dated 10/19/2024 at 14:23 (2:23 PM), the progress note stated the resident had a physical altercation with another resident. The altercation was not reported to management or the Administrator on 10/19/2024. The MDS Coordinator notified the Administrator as soon as she read the progress note on 10/21/2024. The incident was reported to the State of Michigan and all appropriate parties were notified. Interviews and an investigation were initiated . In an interview on 1/28/25 at 12:00 PM, Director of Nursing (DON) B reported abuse or potential abuse was expected to be reported immediately to the abuse coordinator (Adminstrator A) or to her, if the abuse coordinator was not present in the building. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy, Abuse Prevention revised on 9/9/2022, revealed, .Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all guests/residents, irrespective of any mental or physical condition, may cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Physical Abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment .G. Reporting abuse and facility Response to the allegation 1. The staff will report any allegations or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown source to the Administrator and DON immediately. 2. The Administrator or designee will notify the guest's/resident's representative. Also, any State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41424 Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 1 resident of 13 (Resident #101) reviewed for care planning resulting in a lack of service for the resident to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #101: Review of an Admission Record revealed Resident #101 was a female with pertinent diagnoses which included Alzheimer's disease, chronic fatigue, diabetes, impulsiveness, chronic pain, psychosis, COPD, and stroke. Review of Care Plan revised on 1/12/25, revealed the focus, .(R101) is at risk for fall related injury and falls R/T (related to): Confusion , Gait/balance problems, History of Falls, Incontinence, Medication, Mobility/uses a device, Unaware of safety needs, (R101) frequently declines assistance from staff for transfers. (R101) is self-determined to maintain her independence and frequently self-transfers/ambulates without calling for assistance and she will exceed her physical capabilities. 12-26-23(R101) continues to have falls despite interventions in place. (R101) has several risk factors that increase her risk of falls including multiple falls in the last 60 days, self-determination and inability to recognize her physical limitations, gait abnormalities, cognitive deficits, and unspecified dementia with behavioral disturbance, use of assistive devices and multiple medications including antihypertensives, antidepressant and antipsychotic medications . with the intervention .5/2/24- Place fall mat next to bed .1/12/25- Concave mattress to bed . Review of Resident #101's medical record revealed the resident had multiple fall incidents. During an observation on 1/23/25 at 09:00 AM, Resident #101 was observed lying in her bed on her right side, eating her breakfast while in bed. Resident #101 did not have a concave mattress nor was there a fall mat on the side of the bed. During an observation on 1/23/25 at 1:47 PM, Resident #101 was observed in bed, enabler bars were up, she was on her side facing the doorway, lying very close to the edge of the bed. No concave mattress or fall mat was observed. During an observation on 1/28/25 at 8:25 AM, Resident #101 was observed lying on her right side, on the edge of the bed. No concave mattress or fall mat observed next to her bed. During an observation on 1/28/25 at 8:59 AM, Resident #101 was observed lying in her bed, close to the side of the bed, arm hanging over the side of the bed, bed was not low to the ground, no concave mattress, and no fall mat in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/28/25 at 10:18 AM, Resident #101was observed lying in her bed, arm over the side, very close to the edge of the bed, no fall mat, and no concave mattress. In an interview on 1/28/25 at 09:08 AM, CNA W reported if the staff had a resident they were not familiar with they would review the kardex (Quick sheet which organized resident's care information). CNA W reported in the computer you could see everything specific on how to care for the resident, if they were a one person, two person or hoyer transfer, personal care like brusing their teeth. In an interview on 1/23/25 at 1:00 PM, CNA M reported she would review a resident's care plan to determine how to take care of a resident. In an interview on 1/28/25 at 12:17 PM, Unit Manager (UM) D reviewed Resident #101's care plan and indicated the resident was to have a concave mattress and a fall mat was listed as an intervention on the care plan as well. In an interview on 1/28/25 at 12:17 PM, Director of Nursing (DON) B reported Resident #101 should have a concave mattress on her bed, but the facility was removing fall mats from the residents' rooms and the care plan should have been updated.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41424 Based on interview and record review the facility failed to ensure facility nursing staff followed physician orders to obtain urine sample in 1 of 13 residents (Resident #101) reviewed for laboratory orders and standard of practice, resulting in the potential for the worsening of a condition and a delay in treatment. Findings include: Resident #101: Review of an Admission Record revealed Resident #101 was a female with pertinent diagnoses which included Alzheimer's disease, chronic fatigue, diabetes, impulsiveness, chronic pain, psychosis, COPD, and stroke. Review of Care Plan for Resident #101, revised on 10/21/24, revealed, the focus, .I have a history of urinary tract infection . with the intervention .Obtain labs/diagnostics as ordered. Report abnormal results to the physician . Review of Incident Report dated 11/21/24, revealed, .Incident Description: Observed pt (patient) lying on her right side on the floor in the bathroom .Obtain U/A (urinalysis)with C&S (culture and sensitivity) in indicated r/t (related to) hallucinations of a person in her room . Review of Order dated 11/21/24 revealed, .Obtain UA with C&S if indicated one time only for hallucinations for 1 day DO NOT CLICK OFF MAR UNTIL OBTAINED . End date as 11/22/24. Reviewed the Medication Administration Record (MAR) for November 2024, revealed the order was not selected for completion which indicated the UA was not performed. In an interview on 1/24/25 at 1:57 PM, Assistant Director of Nursing (ADON) C reported the order was not clicked on which indicated it was not completed when Resident #101's medical record was reviewed with this writer. ADON C reported since it wasn't clicked in the MAR, then the order was not done. In an interview on 1/28/25 at 12:07 AM, Director of Nursing (DON) B reported the nurses confirmed the order and would mark off the MAR when it was completed. DON B reported the labs were discussed at the stand up meetings and if it was not done could follow up on that being completed. DON B reviewed the record and indicated the facility could not find the completed lab, indicated the lab was not done and it should have been completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41424 This citation pertains to Intake: MI00146669 Based on interview and record review, the facility failed to ensure a resident was consistently provided with showers/bathing for 2 of 8 residents (Resident #100 and #101) reviewed for activities of daily living, resulting in unmet personal hygiene needs with the potential for isolation, psychosocial harm, skin breakdown, harboring infection, and decreased self-esteem. Findings include: Resident #100: Review of an Admission Record revealed Resident #100 was a female with pertinent diagnoses which included heart failure, diabetes, COPD, fibromyalgia (chronic health condition that causes pain, tenderness throughout the body, fatigue, and trouble sleeping), peripheral venous insufficiency (veins in legs and arms are damaged or blocked, making it difficult for blood to return to the heart, can lead to swelling, pain, cramping). Review of Care Plan revised on 1/6/25, revealed the focus, .Has a functional ability deficit and requires assistance with self care/mobility r/t (related to): fatigue/weakness, impaired balance . with the intervention . Bath/Shower-Substantial/Maximal assistance with one helper . Review of Task - Showers for Resident #100's for the previous 30 days, revealed, .12/27/24: N/A (not applicable; 1/7/25: N/A; 1/10/25: N/A; 1/14/25: No (refusal was not selected and no documentation in record to why not received a shower) . In an interview on 1/24/25 at 10:55 AM, Complainant MM reported residents would ask for showers, told they would get a shower, and then they wouldn't receive one. Complainant MM reported there were times the residents would go a week at least without a shower and staff were not offering them to shower or even give them a bed bath. Resident #101: Review of an Admission Record revealed Resident #101 was a female with pertinent diagnoses which included Alzheimer's disease, chronic fatigue, diabetes, impulsiveness, chronic pain, psychosis, COPD, and stroke. Review of Care Plan revised on 7/25/24, revealed the focus, .(R101) has a functional ability deficit and requires assistance with self care/mobility r/t: impaired balance, impaired cognition, impaired mobility, pain, impulsiveness, hx of falls, COPD, DM2 (type 2 diabetes), mediation side effects . with the intervention . Substantial/maximal assistance) with (one, two) helper(s) Report refusals of ADL care, personal hygiene, nail care, bathing, and showers to the nurse . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Task - Showers for Resident #101's for the previous 30 days, revealed, .1/4/25: No; 1/8/25: N/A; 1/11/25: No (No documentation in the record of LOA (Leave of absence) or refusal); 1/15/25: N/A; 1/18/25: Refused .(Note: no documentation in progress notes of resident refusal documented by nurse). In an interview on 1/24/25 at 1:23 PM, Certified Nursing Assistant (CNA) M reported the CNAs were not supposed to make not applicable for the documentation of showers. CNA M reported the residents either get a bed bath or a shower, and if they refused the shower/bath we would still wash them up and inform the nurse the resident refused. In an interview on 1/24/25 at 1:09 PM, CNA GG reported a substantial maximal assist would mean she would do quite a bit of the heavy lifting. CNA GG reported when a resident refused a shower/bath they would reapproach 3 times throughout the day, try to maintain their preference for shower times, like if the resident preferred morning showers. CNA GG reported once they have tried and the resident still refused then CNAs would document in the record, and would let the nurse know that the resident refused. CNA GG reported when a resident took a shower the CNAs would also perform a review of their skin and report any changes to the nurse. In an interview on 1/24/25 at 11:52 AM, Unit Manager (UM) D reported when a resident refused a shower/bed bath the CNAs would attempt again, have another staff member approach, and if the resident was still refusing the CNAs would notify the nurse to approach the resident for a shower/bed bath. If the resident still refused, the CNA would document in their documentation and the nurse would place a note in the resident's medical record.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview and record review, the facility failed to provide consistent, meaningful, person-centered activities for 2 of 2 residents (Resident #102, #104) reviewed for activities provided by the facility, resulting in the potential for loss of interaction, joy, self-esteem, growth, sense of wellbeing, autonomy, connectedness, identity, creativity, independence, pleasure, and comfort. Findings include: Resident #102: Review of an Admission Record revealed Resident #102 was a female with pertinent diagnoses which included intellectual disabilities, bipolar disorder, anxiety, schizoaffective disorder (combination of symptoms of schizophrenia (serious mental illness that affects how one thinks, thoughts or experiences that seem out of touch with reality, disorganized speech or behavior, decreased participation in daily activities) and mood disorder), and restlessness and agitation. Review of Care Plan for Resident #102 dated 4/12/24, revealed the focus, .I have a psychosocial well-being problem, I sometimes am overwhelmed by my emotions and struggle to cope with them appropriately which may lad (sic) to excessive crying, bathroom accidents, skin picking .From (community mental health): Patient may act out behaviorally towards staff when she is upset or in pain . with the intervention .Create a list of favorite activities such as coloring, visiting with others, pet therapy, walking the halls, and other activities she demonstrates enjoyment from .Provide me with as many situations as possible which give me control over my environment & care delivery, ASK ME WHAT I PREFER! Thank me for participating .When conflict arises, assist me to a calmer environment and allow me to vent/share feelings . Note: This writer did not observe resident participating in activities or one to one activities. Review of facility investigation dated 11/2/24, revealed, .On November 2, 2024, at approximately 1:15 PM, a certified nurse assistant witnessed (Resident #102) strike (Resident #101) in the face with a closed hand . During the investigation/interviewing process, (LPN I) states, directly after meal times can be an issue for (Resident #102) as she may experience other residents commuting to and from the dining room and can be upset about other resident's being in the same area as her. (LPN I) communicated with the staff on duty that (Resident #102) would benefit from activities directly after meals as an intervention for (Resident #102) .(Unit Manager (UM) D) - Unit Manager states (Resident #102) can be behavioral at times, especially if she is not able to do what she wants the second she wants to do it, for example if she wants to go for a walk and you tell her you will be back in 5 minutes she will stomp her feet and cry, sometimes she will cuss at you as well. I (UM D) understand she is difficult to understand at times as well and the staff try their best to understand her needs . Review of eMar - Shift Level Administration Note dated 10/22/2024 at 10:41 AM, revealed, .resident self-propelling wheelchair to middle of hallway, began yelling at staff and spitting at them. Resident began yelling to 'go for walk 'when informed we can take her for a walk later, she began getting mad and showing the nurse the middle finger . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Psychoactive Medication Quarterly Evaluation dated 1/10/25, revealed, .Interventions have been effective? Assessing of needs, offering distractional activities, taking a stroll through facility, noise cancelling headphones, 1:1 activity, redirection, alternate caregiver, reapproach, music therapy, supportive visits with CMH (community mental health) and being seen by (psychological services provider) are in place and varies in effectiveness . Review of Task - Activities for November 2024, revealed, Resident #102 had 8 days of one to one activities. Review of Task - Activities for December 2024, revealed, Resident #102 had 5 days of one to one activities. Review of Task - Activities for January 2025, revealed, Resident #102 had 2 days of one to one activities. During an observation on 1/24/25 at 9:20 AM, Resident #102 was asking to go for a walk and AA K told her that she had to pass out the chronicles, read them and then exercise. CNA M entered the day room and was prompting another resident to eat her breakfast and assisted with her starting to eat and then proceeded out of the day room. During an observation on 1/28/25 at 9:20 AM, Resident #102 was asking to go for a walk, AA K told her that she had to pass out the chronicles, read them and then exercise with the other residents. At 9:20 AM, the memory care day room did not have any staff members to supervise the day room. In an interview on 1/28/25 at 10:42 AM, Social Services Director (SSD) EE reported Resident #102 needed redirection and provided one to one activity support. SSD E reported Resident #102 likes to complete a job and staff would give her different tasks to complete like delivering mail, folding laundry, little type stuff like that. SSD EE reported Resident #102 liked to attend bingo, church, take strolls. SSD EE reported she tried to spend quite a bit of time with Resident #102 as well as AD P did as well. SSD EE reported she was the only social services staff member with 95 residents and there was a lot to do. *Note: During times this writer was on the memory care unit from 1/22/25 - 1/28/25 this writer did not observe SSD EE on the unit. Resident #104: Review of an Admission Record revealed, Resident #104 was a female with pertinent diagnoses which included anxiety, restlessness and agitation, cognitive communication deficit, mood disorder, and severe intellectual disabilities. (continued on next page)

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	235264	A. Building B. Wing	01/28/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Care Plan for Resident #104, revised on 9/25/24 revealed the focus, .I have severe impaired cognition function or impaired thought processes r/t (related to) developmental disability .I may yell out at times to express my needs. I will also increase my yelling and sometimes cry when I want attention .Patient is able to communicate verbally and nonverbally using hands, and gestures . with the intervention .6/1/24: OBRA recommendations for recreational therapy staff to provide regular one to one visits .6/1/24: Monitor patient in common areas, and redirect out of crowded spaces patient may become upset trying to maneuver out of crowded spaces .7/6/23: Place my side table in the day room, away from the doorway as I will allow to reduce the risk of other residents unknowingly entering my personal space as I tend to dislike others close to me .11/11/24: Seat me independently at a table or out of reach from other residents during activities as I will allow . Review of Nurses Notes dated 11/8/2024 at 1:15 PM, revealed, .CNA reported to the writer that resident initiated physical aggression to another resident on the hallway when another resident was passing on his wheelchair, resident hit with elbow another resident on his right arm. Residents separated immediately and put on cont. monitoring through the day . Review of Social Services Note dated 11/7/2024 at 1:53 PM, revealed, .SW (Social Worker) went to do a wellness visit with (Resident #104). (Resident #104) was in the hall when the SW approached and yelling, when she put up her hands as she was going to push or hit the SW. SW stated hi (Resident #104), would it be okay if I spent some time visiting with you. (Resident #104) then stated something that was not understandable. (Resident #104) grabbed ahold of the hand of the SW and hugged the SW hand . Throughout the visit with (Resident #104) she was pleasant and sociable, but not understandable with her speech and demonstrated a flat affect. At the start of the visit (Resident #104) demonstrated irritation when SW first seen her and started the interaction. By the end of the interaction resident showed no signs of distress or discomfort. SW ended the visit . During an observation on 1/28/25 at 08:41 AM, this writer observed no one was in the day room, Resident #104 was being very vocal, raising her voice, she appeared agitated. She was on the other side of the table by the tv side self-propelling herself around and then proceeded towards the other side of the day room. During an observation on 1/23/25 at 9:37 AM, Resident #104 had self-ambulated to the tv room/dining room area with other residents, she did not have her tray table with her nor was it noted in the hallway by her room. In an interview on 1/28/25 at 10:42 AM, Social Services Director (SSD) EE reported Resident #104 had developmental delays and her understanding of situations was difficult. SSD EE reported if Resident #104 did not have someone next to her she would not participate in activities. SSD EE reported she was tracking her behaviors and Resident #104 may think someone going to pick up an item may touch or interrupt her, and she might swing or hit. SSD EE reported it was important for Resident #104 to have one to one visits with the activities department or nursing doing one to one therapy, reading a book, pictures books, and be mindful as she doesn't like people close to her. SSD EE reported the tray table allowed for her to have her own little private space to not be bothered and sometimes to be set it up in the hallway. Review of Task-Activities for November 2024, revealed, Resident #104 had five days of one to one activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Task-Activities for December 2024, revealed, Resident #104 had four days of one to one activities. Review of Task-Activities for January 2025, revealed, Resident #104 had one day of one to one activities. During an observation on 1/23/25 at 12:40 PM to 1:47 PM, observed in the day room on the memory care unit there was not an activities aide on the unit and no one supervising in the day room. Activities Aide (AA) HH was observed walking around out in the main area but not actively engaging residents with activities. During an observation on 1/23/25 at 3:31 PM, observed no activity staff or nursing staff in the day room for the memory care unit. Resident #102 and Resident #104 were in the dayroom. Resident #104 was seated at the larger table in front of the TV with other residents. Resident #102 was seated in her wheelchair by the other side of the table by the living room chair along the far right wall where other residents were seated. She was drinking hot chocolate. During an observation on 1/24/25 at 9:56 AM, AA K not in the day room she was observed off the unit on the rehabilitation hallway. In an interview on 1/23/25 at 8:40 AM, AA K reported the activity department staff worked between the memory care unit and the other units during the day. AA K reported typically there were supposed to be three AAs, with two one day a week, but we can be down due to life events. AA K reported every other weekend she would work and there would be only two of us. AA K reported the AA shifts were 8:00 AM -4:30 PM, and 10:00 AM to 6:30 PM. AA K reported we don't have staff in the facility after that time as most residents don't want to do activities and were going to bed. In an interview on 1/24/25 at 11:09 AM, CNA F reported the activity department was cut at one time, the facility did not have any activity aides. The staff on the memory care unit had been asking for an activities aides on the unit due to so many resident to resident incidents. The facility started to have AA's on the unit, but they were not always on the unit and residents weren't being supervised because the CNAs were busy completing cares for residents. In an interview on 1/28/25 at 12:29 AM, Administrator A reported she believed the number of resident and resident incidents were due to a combination of things such as those residents who were repeat offenders, new staff members who were learning how each resident was, not having consistent staff on the memory care unit. Administrator A reported the facility had done some shifting on staff and was placing an activities office in the memory care unit which should help with the supervision of the residents and hopefully reduce the number of behavioral situations in the facility. Administrator A reported the facility had activities staff in the memory care unit to implement daily activities for the residents but had lost some activities staff for the department. Administrator A reported the interdisciplinary team was discussing where to place those residents with frequent behaviors, once the doors to the memory care unit was opened, to be able to stay on top of the residents and hopefully prevent further resident to resident incidents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of The Boredom of Solitude published 4/21/23 by Psychology Today, [NAME] Danckert Ph.D., [NAME], Ph.D., revealed .Loneliness is a complex experience, one that can heighten our sense of vulnerability .which leads to elevated stress . and just like boredom, loneliness has been associated with poor mental health, challenges to cognitive function, and even cognitive decline in the elderly .perceived lack of meaning will color things as being boring. So, to solve loneliness, like solutions to boredom, we can't simply reach for any kind of interaction. We need things that are meaningful to us. Review of Activity Involvement and Quality of Life of People at Different Stages of Dementia in Long Term Care Facilities, [NAME] & Twist (2015), published in Aging Mental Health, revealed Despite a Resident's cognitive status, their activity involvement was significantly related to better scores on care relationships, positive affect, restless tense behavior, social relations and having something to do.

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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** 41424 This citation pertains to Intake: MI00148896 Based on observation, interview and record review, the facility failed to provide adequate supervision, implement care plan interventions, and assistive devices for proper transfer for 1 (Resident #108) of 4 residents, resulting in a fall which had the potential to cause injury and negatively affect the residents highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #108 (R108): Review of an Admission Record revealed Resident #108 was a female with pertinent diagnoses which included unsteadiness on feet, weakness, and low back pain. Review of current Care Plan for Resident #108, revised on 11/12/24, revealed the focus, .(R108) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): weakness, impaired mobility, non-ambulatory since back surgery in March 2024, DM (diabetes mellitus), morbid obesity . with the intervention .Substantial/maximal assist with sit to stand two persons . Review of Incident Report dated 12/2/24 at 09:30 AM, revealed, .Called into resident room by CNA-Upon entering the room the resident was at the edge of the bed, feet spread out in front on the floor to avoid sliding onto the floor, both arms on the bed behind the resident. CNA states she was transferring (R108) who became weak and was unable to make it completely into bed. Assisted the CNA with positioning the resident into bed fully .Immediate Action: no injuries observed . Review of Progress Note dated 12/3/24 at 00:00, revealed, .Chief Complaint: Provider is seeing patient today at the request of the staff and patient due to pain in patients left upper arm after she fell on ,d+[DATE] . Provider saw patient while she was laying in her bed in her room. Patient reports pain in her left upper arm. She states that yesterday she was being transferred from her wheelchair to her bed and fell into bed. She reports that she was being assisted by one staff member. Patient states that she got tangled when getting into bed and her left arm hit something hard on the bed. Since that time patient reports that she has developed pain in her left upper arm. Point tenderness noted to patients left mid humerus. Patient denies numbness and tingling in left arm and hand. Patient is able to move LUE (left upper extremity) through all AROM (active range of motion). X-ray of the left upper arm and elbow will be ordered to evaluate for possible fracture. No other injuries from fall reported. No acute concerns from staff . Review of Radiology Report dated 12/3/24, revealed, .SHOULDER COMPLETE MIN 2V, LEFI Results: Possible acute minimally impacted transverse humeral neck fracture with subtle cortical irregularity. No joint dislocation. No comparison study .Conclusion: Possible acute minimally impacted humeral neck fracture. Consider more sensitive imaging evaluation with CT as clinically directed . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Note dated 12/4/24 at 00:00, revealed, .Provider saw patient while she was sitting in her room in a wheelchair getting ready to go to therapy. Patient was informed that her x-ray showed a possible acute minimally impacted humeral neck fracture of the left arm. Patient informed that the suggestion is to get a CT image to obtain bettor imaging and assist with plan of care moving forward. Patient made aware that this order was placed by provider and is being scheduled for as soon as possible. At this time patient and facility staff/therapy staff have been informed that patient should not put weight into, push or pull using left arm. Patient and staff in full understanding. Patient has been prescribed pain medication for management of pain left arm. No acute concerns from staff or patient . Review of CT Humerus Left without Contrast dated 12/12/24 at 1:35 PM, revealed, .IMPRESSION: 1. No acute fracture .2. Severe glenohumeral osteoarthrosis (shoulder joint parts wear down and cause pain and stiffness) with a small joint effusion (swelling due to excess fluid) and chondrocalcinosis (sudden, intense joint pain, stiffness, and inflammation) .3. Findings that could represent chronic sequela of a rotator cuff tear (persistent pain, decrease range of motion, rotator cuff tear that has not been properly addressed or healed) . In an interview on 1/22/25 at 09:08 AM, Resident #108 reported Certified Nursing Assistant (CNA) M when she transferred her did not use a gait belt and she messed up her arm and her back. She indicated the wheelchair was located at the side of the bed at an angle at foot of the bed and she was trying to sit her on the side of the bed and it didn't happen at all and she had a fall, missed the side of the bed and fell into the side of the bed. In an interview on 1/23/25 at 12:25 PM, CNA M reported Resident #108 was in her wheelchair and trying to sit her on the edge of the bed, Resident #108 was pivoting, she was pivoting to her left, wheelchair in position it is now (at an angle at the side of the foot of the bed). CNA M reported she thought Resident #108 was a one person assist, as she knew she had been working with therapy, she told me could do a one person transfer. CNA M reported she didn't look at her care plan, she was not her assignment, and CNA M reported she was just answering the call light. CNA M reported she asked another staff member who told her that she was a one person, and maybe a sit to stand, but can't remember. CNA M reported she did have the gait belt on Resident #108 and reported when you transfer a resident they should have a gait belt on them. CNA M reported Resident #108 was having trouble pivoting and she was trying to guide her to the side of the bed and she sat down on the edge of the bed barely with her bottom on the bed. CNA M reported she yelled for help and Licensed Practical Nurse (LPN) L came to assist her. In an interview on 1/23/25 at 1:17 PM, LPN L reported CNA M yelled for help and she went in there and Resident #108 was sitting on the bed, she was leaned back in the bed. LPN L reported they used the draw sheet to assist in transferring the resident all the way in the bed. LPN L reported Resident #108 was a larger lady glad they had the draw sheet to reposition her, leaning back holding self up with arms. LPN L reported she assisted with repositioning the resident's feet and they used the draw sheet to pull her up in the bed as she was at side of the foot of the bed. LPN L reported when she entered the room CNA M was standing with her legs split between Resident #108's legs to help keep the resident from sliding onto the floor. LPN L reported there were no complaints of pain that day but the next day Resident #108 indicated she had pain. LPN L reported she did not think it was a fall and did not perform a formal assessment on the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/24/25 at 10:28 AM, Physical Therapist (PT) N reported after the incident happened, CNA M came back to the gym and let me know that it happened and informed her Resident #108 was supposed to be a two person transfer. Review of facility process document, Proper Use of a Gait Belt? and Transfers with a Gait Belt received on 1/24/25, revealed, .Explain the procedure to the resident .Apply gait belt while resident is in a sitting position . Safety/gait belts should be applied around the resident's waist, just above the hips and well below the ribs . Place the buckle on the weaker side .Safety/gait belt should be snug (insert no more than 2 fingers underneath the gait belt) .Re-adjust the belt once the resident stands .Bend your arms, keeping your elbows at your side with palms up .Place both hands under the belt, one on each side of the resident's waist .Protect the resident's skin from the buckle .Lift with your knees when moving the resident from sitting to standing .Do not have the resident place his/her arms or hands around your neck during the transfer .