STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235267	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Kingsford	1225 Woodward Avenue Kingsford, MI 49801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49397 This citation pertains to Intake MI000142093. Based on observation, interview, and record review, the facility failed to follow through with the grievance process initiated by resident representatives regarding resident care and by the resident council (10 members in attendance) related to snacks not being provided in the evenings. This deficient practice resulted in the residents and their representatives' grievances not being resolved or followed up on for those who filed grievances, with the potential for other grievances to go unanswered for any of the other residents at the facility. Findings include: (All reported times are in Eastern Daylight Time) During an interview on 5/19/24 at 3:08 PM, Resident #37's (R37) representatives voiced concerns the grievances they had filed were not addressed. R37's representatives had not been notified of action taken on their concerns. A grievance filed on 2/7/24 by R37's representatives read in part .not sure if this complaint will get to the right department/person because we have filed complaints in the past with different issues/concerns and no response. The Director of Nursing (DON) was supposed to follow up and get back to us after meeting with him after dad got out of hospital. We would appreciate follow up moving forward if our dad is in your hands/care. Grievance form was marked as yes to indicate resolution of concern with one-on-one discussion to resident 37's representative. During follow-up interview on 5/22/24 at 10:22 AM with R37's representative, she stated that she had not been followed up with regarding this grievance. Review of the facility's Resident Council meeting minutes from January 2024 to April 2024 and revealed that the resident council had made concerns that snacks were not being made available in the evenings in the January, February, March, and April meeting minutes. During resident council meeting on 5/20/24 at 3:48 PM, the resident council members voiced concerns of lack of grievance follow through. They stated that they had given the activities director their filled out grievances. The resident council members stated they did not feel that the grievances they had filed regarding evening snacks starting on 9/12/23 were addressed, as some resident halls were still not being offered evening snacks on a regular basis. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted on 5/20/24 at 4:10 PM with the activities director verified that she had indeed filed the resident council grievances regarding afternoon snacks and that the resident council were very concerned about getting their afternoon snacks. An interview conducted on 5/20/24 at 4:48 PM with confidential staff ZZ who revealed that they had taken grievances from residents, submitted them appropriately, without any indication of the concern being addressed. During one grievance submission process by ZZ, it was noted that at least two filled out grievance forms with one dated 11/22/23 were in the trash can in the NHA's (Nursing Home Administrator) office, without follow up being completed. ZZ documented the grievances in the trash by taking photos. ZZ was concerned that the grievance process had not been adhered to. Review of the facility's Investigations of Grievances policy dated 10/1/22 read in part concerns may be forwarded directly to the department involved for resolution. Grievances will be raised to the level of the Director of Nursing or designee on duty .The Director of Nurses is responsible to ensure the proper investigation and follow-up is conducted .It is the responsibility of the Administrator as the designated grievance official for the facility to review each written grievance for proper investigation, follow-up, and resolution. Resolution of the grievance will be relayed to the complainant upon completion. Grievance details will be kept no less than three years from the date of the grievance decision.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intake MI00142093 and MI00142802. Based on observation, interview and record review, the facility failed to implement a comprehensive wound care program which resulted in Immediate Jeopardy with identification of the development of multiple facility acquired stage III/IV/Unstageable facility acquired pressure injuries and/or worsening of existing pressure injuries for four Residents (R4, R19, R38, and R48) of five Residents reviewed for pressure injuries. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. R4 developed two facility-acquired unstageable/Stage 3 pressure injuries. R19 developed a right heel wound infection requiring surgical debridement and administration of IV (intravenous) antibiotics, and developed a new, facility-acquired left heel deep tissue injury (intact skin with damage of underlying soft tissue from pressure) without implementation of interventions to prevent worsening of the wound. R38 developed a facility-acquired pressure injury which deteriorated from Moisture Associated Skin Damage (MASD) [Inaccurately identified] which deteriorated to a Stage 4 pressure injury to the coccyx (tailbone)[Inaccurately identified as unstageable] requiring the use of antibiotics for a subsequent wound infection. R48 lacked essential skin care interventions to prevent the development of additional facility-acquired pressure injuries, experienced worsening of a Stage IV sacral injury, and was observed being provided with inadequate wound care technique to prevent wound infection. The Immediate Jeopardy identified on 5/20/2024, began on 3/08/2024 when R38 was assessed with a facility-acquired Stage 4 pressure injury (wound covered with extensive dead tissue, if removed would reveal a full-thickness wound) to the coccyx following incomplete assessments and inaccurate identification of the wound as moisture-associate skin damage (MASD). All times are recorded in Eastern Daylight Time (EDT), unless otherwise noted. Resident #19 (R19) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the Electronic Medical Record (EMR) revealed R19 was admitted on [DATE] with diagnoses including coronary artery disease, diabetes, peripheral vascular disease, and osteoarthritis. Review of R19's quarterly Minimum Data Set (MDS) assessment, dated 3/14/2024, revealed he was dependent (Helper does all the effort. Resident does none of the effort to complete the activity) on staff for dressing, putting on/taking off footwear, and all mobility including rolling left to right, sitting to lying, lying to sitting, transfers and wheelchair mobility. Further review of the MDS assessment revealed R19 was assessed as experiencing pain that interfered with day-to-day activities almost constantly and had one unhealed, unstageable (not stageable due to the coverage of the wound bed by necrotic tissue) pressure ulcer. R19 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he was cognitively intact. An observation on 5/19/2024 at 2:49 p.m., revealed R19 lying in bed with his hips and upper body leaning to the left side of the bed wearing a blue foam heel protection boot on his right foot. R19 was not wearing footwear on his left foot, and his left heel was observed to be resting completely on the mattress. A pillow was observed to be under R19's lower legs. It was noted the pillow was flat and did not elevate R19's heels from the surface of the bed. On 5/19/2024 at approximately 2:54 p.m., immediately following the initial observation, R19 could be heard in the hallway yelling out for help. Certified Nurse Aide (CNA) N and CNA W entered R19's room and closed the door. Upon entering the room, CNA N reported they were preparing to reposition R19 in bed per his request. After repositioning R19 on his right side, CNA N replaced the flattened pillow under R19's lower legs. R19 was wearing a blue, heel protection boot on his right foot and his left foot was bare. R19's left foot was observed to be turned inward, with the medial aspect of his heel and ankle resting directly on the mattress. Registered Nurse (RN) X entered the room at that time and was observed standing on the left side of R19's bed, speaking with R19. RN X was in full view of R19's heels resting directly on the bed and did not attempt to reposition R19 or instruct CNA N and CNA W to reposition R19, so his heels were not resting directly on the bed. RN X, CNA N and CNA W left the room without elevating R19's heels. An observation on 5/20/2024 at 8:40 a.m. revealed R19 lying in bed, tilted to his left side with the head of the bed at approximately 45 degrees. The blue heel protection boot was on R19's right foot. R19 was not wearing footwear on his left foot and his left heel was observed to be resting fully on top of a flattened pillow positioned directly under his feet. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on 5/20/2024 at 11:30 a.m. revealed CNA N and two unidentified students enter R19's room. CNA N informed R19 they were going to prepare him for transport to an outside appointment with his Urologist. Upon removal of R19's sheet, he was observed to be wearing a blue heel protection boot on his right foot. R19 was not wearing footwear on his left foot and his left heel was observed to be resting directly on the bed. CNA N removed the blue heel protection boot from R19's right foot revealing an elastic material wrap on R19's foot extending from the base of his toes and over R19's heel and ankle. During repositioning, CNA N lifted R19's left leg, revealing an area approximately 1.5 in. (inch) by 1 in. of dark purple discoloration on the medial aspect of R19's left heel. Further observation revealed a black spot near the center of the dark purple area and the skin surrounding the discoloration appeared reddened. CNA N stated R19 was supposed to have a heel protector boot on his left foot. When asked where the boot was and why it had not been observed on R19, CNA N stated, we keep telling them (nurses/managers) he needs one, but we still don't have one. Further observation revealed CNA N and a student position a lift sling under R19 and began lifting R19 over the bed. Upon lifting R19 was observed yelling out it hurts, it hurts, I can't take it! R19 was lowered back onto the mattress. CNA N then asked R19, do you want to cancel your appointment? R19 reported he did not think he could take it. Review of R19's May 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the following physician orders: Change bandage to right heel, cleanse with normal saline, apply silverderm 7 and cover with heel foam adhesive, comparable bandages may be used. Every evening shift every Tue [Tuesday], Thu [Thursday], Sat [Saturday] for wound. Order Status: Active . Order Date: 4/23/2024 . Start Date: 4/25/2025. Heel protection boots to bilateral feet every shift. Order Status: Active . Order Date: 5/16/2024 . Start Date: 5/16/2024. It was noted in review of R19's May 2024 MAR and TAR, nursing staff documented heels boots were in place on both of R19's feet for the 6:00 a.m. - 2:00 p.m. shift on 5/19/2024 and 5/20/204, contrary to CNA N reporting no heel protection boot available for R19 and the observations of R19's left heel resting directly on the bed on 5/19/2024 and 5/20/2024. Offload heels while in bed to prevent ulcers. Every shift for prevent pressure [sic]. Order Status: Active . Order Date: 4/18/2024 . Start Date: 4/18/2024. It was noted in review of R19's May 2024 MAR and TAR, nursing staff documented R19's heels were offloaded on 5/19/2024 and 5/20/2024, contrary to the observations on 5/19/2024 and 5/20/2024, of R19's left bare heel and right heel with a heel protection boot resting directly on the bed. Immediately following the observation, Unit Manager and Registered Nurse (RN) L entered R19's room and asked the Resident if he wanted to cancel his appointment. R19 explained to RN L the pain in his back was severe and he did not think he could handle the pain from the movement involved in transport. R19 asked why can't they give me something [for the pain] before [appointments]? RN L told R19 she could speak to the physician about pain medication prior to outside appointments but would cancel his appointment for that day. No education was provided to R19 related to the importance of keeping the appointment or offer made for pain relief medication at that time so R19 could attend the appointment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/20/2024 at 4:00 p.m., R19 reported he was aware he had a wound on his right heel. R19 reported his right heel had healed after admission to the facility but since that time opened back up and worsened. R19 reported being recently hospitalized due to an infection of the right heel wound. R19 reported no injury to his right or left heels and was unaware of the area of discoloration found on the medial aspect of his left heel. R19 reported his feel always rested directly on the mattress or directly on a pillow, never floated above the mattress, and he had never been provided a heel protection boot for his left foot. R19 pulled up his sheet at which time his left foot was without footwear and his left heel was observed to be resting directly on the bed. R19's right foot, in the blue heel protection boot, was observed to be resting on top of his left foot, pushing his left heel into the bed. R19 reported the right heel protection boot was in place off and on since he returned from being hospitalized although he could not remember when the hospitalization occurred. R19 reported constant, severe pain from arthritis in his lower back that made it difficult for him to move his lower body without assistance. A review of R19's Medication MARs and Tars from March 2024 through May 20, 2024 at 2:16 p.m., revealed no order for medication to be administered or pain relief interventions to be implemented in addition to R19's scheduled medications, prior to R19's scheduled appointments with outside providers. R19's May 2024 MAR and TAR also revealed an order for acetaminophen . give 650 mg [milligrams] by mouth every 4 hours as needed for pain. No dose was recorded as administered on 5/20/2024. Review of R19's General Progress Note, dated 4/13/2024 at 6:19 p.m. (Central Daylight Time, CDT) revealed the following: 1700 (5:00 p.m. CDT) Resident noted to be very lethargic with decreased level of consciousness throughout day . skin cool to touch and extremities cold. Feet are mottled . 911 called and will send transport . 1755 (5:55 p.m. CDT) Ambulance here 1809 (6:09 p.m. CDT) Resident has left facility . Review of R19's hospital progress note, dated 4/15/2024 at 8:40 a.m. CDT, revealed the following, in part: Chief Complaint: unresponsive episode . 4/14/2024 upon evaluation of [R19] this a.m. noted to be mumbling, yelling at times and moving about the bed without following directions. Evaluated [R19's] work up and noted right heel ulcer with a very foul odor . [preliminary] right wound heel positive for gram [positive] and gram [negative] bacilli [bacteria] . 4/15/2024 spoke with [podiatrist] this a.m.: [R19] NPO [nothing by mouth] for surgical debridement [removal of dead tissue] . no seizure activity since admission . Physical Exam . Skin: malodorous right heel wound, although covered odor emits entire bed area . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R19's Discharge Summary [acute care facility], dated 4/18/2024 (no time provided), revealed the following, in part: Date of Admission: 13-Apr-2024; Date of Discharge: 19-Apr-2024 . History of Present Illness . noted right heel wound with very foul odor . concern for infection causing his leukocytosis (elevated white blood cell count, indicating infection) and mental status changes. 1 of 2 [blood cultures] returned positive for gram [positive] cocci [bacteria] in clusters: on Iv [intravenous] vancomycin [antibiotic often used to treat multi-drug resistant organisms] with IV zosyn [antibiotic commonly used for broad antimicrobial coverage and in early sepsis and critically ill patients] . Hospital Course: . 1. Seizure-like activity: CT head without acute abnormality . 2. Unresponsive episode: Prior to arrival; altered mental status and drowsy . thought to be more likely to polypharmacy . 3. Leukocytosis with right heel ulcer: Right heel likely cause of leukocytosis due to foul odor . WBC: 22.7 [normal range is 4-11] . Lactic 1.1 . Wound [culture] proteus mirabilis [bacteria spread through contaminated objects and surfaces] . 11. Meningioma (brain tumor} CT of head . essentially unchanged from prior . Discharge Instructions: . Pt needs the following follow-ups which can be arranged by nursing home based on available transportation: F/U with [Podiatrist] . in 7-14 days . See wound care orders as written by [Podiatrist] . Review of R19's podiatrist consultation note, dated 4/15/2024 and signed 4/16/2024 at 11:57 a.m. CDT, revealed the following, in part: Assessment: Mixed etiology diabetic [injuries resistant to healing]/pressure ulcer on the right heel . Infected ulcer, right heel . I recommend surgical debridement of the ulceration on the right heel in the operating room with sedation and local anesthesia . The son decided to go ahead and sign the consent for the patient to have a surgical debridement of the ulceration on the right heel later today . Review of the Podiatrist's written Physician Orders, for R19, dated 4/15/2024, revealed the following: Orders for nursing home: . Monitor for infections and call wound clinic if signs of infection occur . Offload heels while in bed to prevent ulcers . [follow up] with [Podiatrist] at wound clinic in 1 month on 5-14-24 [at] 9:30 [a.m. CDT]. A review of R19's EMR revealed no documentation for the wound clinic appointment scheduled for 5/14/2024 at 9:30 a.m. (CST) per the Podiatrist's written order. Further review of the R19's EMR revealed no visit notes from the wound care clinic related to R19's care to include wound assessments, change in condition, or procedures conducted for any of R19's visits to the wound care clinic since admission to the facility on [DATE]. Review of R19's progress note dated 5/16/2024 at 12:27 p.m. (CDT) revealed the following: Resident noted with suspect deep tissue injury to left heel. Skin discolored, non-blanchable [discoloration of the skin that does not turn white when pressed, abnormal finding] and intact. Unit Manager aware. Fax to [physician]. [New order] for barrier cream to left heel every shift and heel protecting boots to bilateral [right and left] feet. A request was made on 5/20/2024 at 4:15 p.m. to the Director of Nursing (DON) for this Surveyor to observe R19's wound care scheduled for 5/21/2024. The DON reported R19's wound care would be completed on the afternoon shift on 5/21/2024 and he would alert nursing staff to inform the survey team when R19's wound care would be provided to allow for the observation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/21/2024 at 1:55 p.m., the Director of Nursing (DON) was asked if nursing was informed of the request to observe R19's wound care scheduled for that day. The DON reported R19 was out of the building for a previously scheduled appointment at the wound clinic, therefore there would be no opportunity for a wound care observation as previously discussed. The DON reported R19 had refused to go to his previously scheduled appointment on 5/14/2024. The DON was asked where the visit notes from R19's wound clinic visits could be located and reported all documentation from the wound clinic was scanned into the EMR under the miscellaneous section. A review of R19's record was conduceted with the DON during this interview which revealed no wound clinic documentation including wound assessments, change in condition, or treatments provided. The only documents found were the Physician Order Details, for R19's visits on 12/6/2023, 2/7/2024, 3/13/2024, and 3/25/2024. The DON reported he was unaware the wound clinic visit notes were not received by the facility. The DON confirmed it was important to have documentation from outside appointments to ensure continuity of care. The DON reported R19 often refused care and refused to be transported to his wound clinic appointments and all refusals should be documented in the Resident's EMR. Review of R19's May 2024 point of care documentation revealed no documentation for turning and repositioning or offloading heels. Review of the May 2024 documentation for the task Behavior Monitoring & Interventions, revealed R19 had no documented refusal of care from May 1, 2024 through May 27, 2024. Review of R19's progress notes for May 2024 revealed one documented refusal of care related to medication administration on 5/13/2024 at 8:34 (CDT). Review of R19's Progress Note Details, received from the wound care clinic and dated 5/21/2024 revealed the following, in part: Wound #5 Right posterior heel . [NAME] Grade 3 diabetic ulcer . measurements 4.5 cm length x 1.7 cm width x 0.3 cm depth with an area of 1.65 sq cm [cm2]. Necrotic muscle exposed . The wound is deteriorating . The ulceration on the posterior aspect of the right heel is necrotic and covered with leathery eschar . The ulceration is fairly large . Procedures: Wound #5 . A skin/subcutaneous tissue/muscle/fascia level excisional/surgical debridement with a total area debrided of 8.46 sq cm [cm2] . An observation on 5/28/2024 at 4:00 p.m. revealed RN PP emerging from R19's closed door. RN PP was asked if the DON alerted her to this Surveyors request to observe R19's wound care. RN PP reported she was aware. RN PP then walked down the hall to the treatment cart and reported the supplies needed for R19's wound care were not in the cart. RN PP left the hall to gather the needed supplies. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/28/2024 at 4:11 p.m. R19 was observed lying supine in bed with a blue foam heel protection boot on his right foot and a white foam heel protection boot on his left foot. R19 was not wearing socks on his right or left foot. Further observation of R19's right foot revealed no wound dressing in place, with R19's right heel and wound resting directly against the surface of the boot with no barrier in between his heel and the foam boot. R19's left heel was observed to be resting on a stack of brown paper towels positioned between his heel and the foam boot. RN PP reported she removed R19's old dressing prior to this Surveyors arrival to R19's room at 4:00 p.m. Further observation revealed RN PP set the wound care supplies on top of R19's over bed table, without a barrier between the supplies and the table. RN PP removed R19's belongings from the table, including a Styrofoam cup with a straw and a half-empty plastic bottle of diet cola. RN PP then entered the bathroom, retrieved brown paper towels from the dispenser and proceeded to wet the towels with water from the sink faucet, and returned to move the supplies to the furthest side of the over bed table. RN PP then wiped down the portion of the table opposite the supplies with the wet paper towel, discarded the paper towel. RN PP then retrieved more paper towel from the dispenser in the bathroom to place on the overbed table where she had just wiped, and moved the wound care supplies to that area, including a can of saline wound cleanser, a foil packet of medihoney, a stack of unpackaged four in. (inch) by four in. (4 x 4) gauze pads and a 2 in. x 2 in. (2x2) adhesive foam dressing. Continuing the wound care observation revealed CNA QQ entered R19's room to assist with R19's positioning during wound care. RN PP positioned the over bed table with the wound care supplies on the right side of R19's bed and instructed CNA QQ, positioned on the left side of the bed, to lift the R19's right leg up out of the foam boot and off the bed. R19's right heel was observed to have a wound extending from the posterior portion of his heel extending to the lateral portion of the heel. The posterior portion was covered with black eschar with the lateral portion of the wound was observed to have a round appearance that was completely covered with shiny, yellow slough. The entire wound was approximately 5 cm long (posterior to lateral) by 2 cm wide. RN PP then sprayed the wound with the saline wound cleanser at which time CNA QQ was observed moving her face back and closing her eyes. RN PP commented to CNA QQ, don't worry, it got me too. Neither RN PP or CNA QQ were wearing eye protection or a protective gown during the observation. After cleansing the wound, RN PP used two of the uncovered, 4 in. x 4 in. gauze pads to pat R19's wound dry then opened the packet of medihoney and squeezed the contents onto a stack of the uncovered 4x4 gauze pads. RN PP proceeded to smear the medihoney over the entire wound bed of R19 and continued to move outward to the surrounding tissue and continued to spread the substance on the healthy tissue surrounding the wound before applying the adhesive, 2x2 foam dressing to cover the wound. It was noted RN PP did not change gloves after cleaning the wound and prior to application of the medihoney and adhesive foam dressing. RN PP was asked if there was a treatment ordered for R19's left heel to which she looked at R19's left foot positioned in the foam heel boot with the brown paper towel between the Resident's heel and the foam boot fully visible before stating there was no treatment ordered for R19's left heel. CNA QQ then lifted R19's left foot out of the foam boot and the Resident's left heel was observed covered with an orange/brown substance. On the medial portion of R19's left heel was observed to have a round area of purple discoloration with a black center. CNA QQ repositioned R19's left foot inside the foam boot, on top of the brown paper towels previously observed. RN PP was then observed removing and discarding her gloves and exiting the room without performing hand hygiene. In an interview immediately following the observation, RN PP and CNA QQ were queried regarding a sign observed to be adhered to R19's doorway referencing the use of Enhanced Barrier Precautions (EBP). CNA QQ stated she forgot EBP was to be used with all close contact care of R19. RN PP reported EBP was only used during catheter care, it's because he has a catheter. (continued on next page)

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Optalis Health and Rehabilitation of Kingsford	1225 Woodward Avenue Kingsford, MI 49801

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of physician orders for R19 revealed the following: Enhanced Barrier Precautions [related to] chronic heel wound and foley catheter every shift. Start Date: 5/06/2024. Order Status: Active. Left heel DTI, paint [with] betadine daily, keep open to air, continue protective padded boot, notify MD if opens, develops eryothemia [sic] . every evening shift for wound dressing. Start Date: 5/21/2024. Order Status: Active. R19's EMR documentation prior to the hospitalization on [DATE], revealed the following: Further review of the EMR revealed the following wound care clinic Physician Order Details: 12/6/2024: Wound #5 Right Heel . Allevyn [special heel shaped, foam dressing] heel dressing or comparable foam . Return Appointment in 4 weeks with the physician - return sooner with new concerns or deterioration of ulcers/wounds, cancel if healed. 2/7/2024 at 10:45 a.m. (CST): Wound #5 Right Heel . Other Orders: Use/Wear off-loading when in bed - keep heels free from pressure at all times, be careful when using lift sling that he does not bang his shins . Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degree tilt. Limit [head of bed] to 30 degrees in bed . 3/13/2024 at 4:04 p.m. (CDT): Wound #5 Right Heel. Primary Wound Dressing: Hydrofera Blue. Secondary Wound Dressing: Tegaderm Foam Adhesive 5.5 x 5.5 [inches] (round) or other adhesive foam . Return appointment in 2 weeks with the physician . Wound Cleansing & Dressing Frequency: . Change dressing(s) BIW [twice per week] . keep heels from pressure at all times . He has difficulty wearing the blue boot at night; I said that he can use pillows at night but wear boot during the day. Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degree tilt. Limit HOB elevation to 30 degrees in bed . The orders were noted by the facility on 3/14/2024 (CDT). 3/25/2024 at 2:21 p.m. (CDT): Wound #5 Right Heel . Return appointment in 2 weeks with the physician . Information included on the order was identical to the Physician Order Details from 3/13/2024. Review of R19's Order Recap Report, dated 11/01/2024 through 5/31/2024, revealed no orders to elevate the resident's heels while in bed or for the use of heel protection boots, prior to the order on 4/18/2023, after R19 returned from hospitalization . Further review of the report revealed an order dated 11/19/2023 to Monitor bed position while sleeping, reposition as needed per care plan every shift for safety. Review of R19's progress notes revealed a General Progress Noted, dated 11/19/2024 at 5:43 a.m. (CST), corresponding to the order, as follows: Resident yelling out in middle of shift and writer observed resident head and shoulders hanging off head of bed. Resident midsection and bottom half of body securely on bed . There was no language in the order referring to the relief of pressure from R19's heels. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R19's care plan, including revisions, accessed on 5/19/2024 at 4:49 p.m., revealed the following: Focus: At risk for alteration in skin integrity [related to] antiplatelet therapy, diabetes, impaired mobility, refuses incontinence cares/repositioning at times, refusals of treatments, elevating heels, repositioning. Reviewed 5/8/24 - No changes. Date Initiated: 11/08/2023. Goal: Decrease/minimize skin breakdown risks. Date Initiated: 11/21/2023. Interventions: . Elevate heels as able. Keep off pressure points as much as possible. Date Initiated: 11/21/2023 . Reapproach if refuses incontinence cares/repositioning - alert nurse. Date Initiated: 12/01/2023 . Focus: Resident has pressure ulcer to right heel. Reviewed 5/8/24 - no changes. Date Initiated: 11/09/2023. Goal: Free from odor . Free from [signs and symptoms] of infection (such as increased drainage/pain/periwound erythema). Date Initiated: 11/09/2023 . Interventions: Administer analgesics as needed . Administer treatment per physician orders . It was noted in review of the care plan, there were no interventions listed to correspond with the recommendations made by the wound care physician to use/wear off-loading when in bed, keep heels free from pressure at all times, be careful when using lift sling that he does not bang his shins . Turn every 2 hours. Avoid positioning direct pressure to wound site. Limit side lying to 30 degree tilt. Limit [head of bed] to 30 degrees in bed . Review of R19's January 2024 point of care documentation revealed no Intervention/Task for turning and repositioning or floating heels and monitoring bed position. Review of the January 2024 documentation for the task Behavior Monitoring & Interventions, revealed R19 was documented as refusing care on 1/1/2024. No other refusals of care were documented for January 2024. Review of R19's February 2024 point of care documentation revealed no Intervention/Task for turning and repositioning or floating heels and monitoring bed position. Review of the February 2024 documentation for the task Behavior Monitoring & Interventions, revealed R19 was documented as refusing care on 2/16/2024, 2/18/2024 and 2/22/2024. No other refusals of care were documented for February 2024. Review of R19's March 2024 point of care documentation revealed no Intervention/Task for turning and repositioning or floating heels and monitoring bed position. Review of the March 2024 documentation for the task Behavior Monitoring & Interventions, revealed R19 was documented as refusing care on 3/1/2024. No other refusals of care were documented for March 2024. Review of R19's April 2024 point of care documentation revealed no Intervention/Task for turning and repositioning or floating heels and monitoring bed position. Review of the April 2024 documentation for the task Behavior Monitoring & Interventions, revealed R19 had no documented refusals of care for April 2024. Review of R19's MARs and TARs for January 2024 through April 2024 revealed no scheduled task or documentation of offloading R19's heels while in bed to prevent ulcers until R19 returned from the hospital on April 18, 2024. During an interview on 5/29/2024 at 12:20 p.m., Unit Manager, RN O reported using water and paper towel to wipe down a surface (action performed by RN PP during a wound care observation on 5/28/2024 at 4:11 p.m.) did not provide required disinfection of the overbed table used to hold R19's wound care supplies. RN O stated staff should use an approved disinfectant and for reference pointed to a purple-topped tube of Sani-cloth Germacidal Disposable Wipes, sitting on the desk behind him. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/28/2024 at 4:50 p.m., the DON, reported EBP should be used for all R19's close contact care, including wound care and catheter care. When discussing R19's right heel wound, the DON reported there was a miscommunication regarding the type of wound the Resident had. The DON agreed the wound could be both diabetic and pressure related. When asked if an order for offloading pressure from R19's heels was ordered prior to R19's return from the hospital on 4/18/2024, the DON stated the order was not placed until after R19's return. Review of the Centers for Disease Control and Prevention (CDC) guideline titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organism (MDROs), dated 4/2/2024, revealed the following, in part: Enhanced Barrier Precautions: Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high contact care activities. Nursing home resident with wound and indwelling medical devices are especially high risk of both acquisition of and colonization with MDROs . An Admission & Re-Admission Evaluation, dated 11/8/2024 at 4:12 p.m. CST (Central Savings Time) accessed on 5/20/2024 at 1:43 p.m., revealed under section XIX. Clinical Evaluation Integumentary (Skin) R19 was assessed as having a right heel open pressure ulcer. Review of R19's initial Skin & Wound Evaluation V7.0, dated 11/9/2023 at 12:52 p.m. CST and accessed on 5/20/2024 at 1:11 p.m., revealed the following: Wound Measurements. Area 0.5 cm2 (centimeters squared). Length 0.5 cm. Width 1.2 cm . Periwound. Edges: Attached: Edge appears flush with wound bed or as a sloping edge . Treatment . Cleansing Solution: Normal Saline . Primary Dressing: Foam . Progress: New . There was no description of the location of the wound, the type of wound, the wound bed or surrounding tissue. It was noted under section H. Treatment. Additional Care no additional care had been marked including the choices of 4. Customized shoe wear . 7. Heel Suspension/Protection Device . 15. Positioning wedge . 17. Turning/reposition program. Review of the photograph attached to the Skin and Wound Evaluation, of R19's right heel revealed an open wound located on the lateral and posterior section of the heel with a red and pink cobblestone appearance to the wound bed that appeared to be granulated tissue (fragile, healing tissue). The area surrounding the wound appeared pink and smooth with a small amount of dry, peeling skin. The evaluation corresponded with the 11/9/2024 evaluation provided by the facility on 5/28/2024. Further review of R19's Skin & Wound Evaluation(s) V7.0, revealed the following: Date: 1/26/2024 at 2:54 p.m. CST, accessed on 5/20/2024 at 1:11 p.m., Type: Pressure. Stage: Deep Tissue Injury: Persistent non-blanchable deep red, maroon, or purple discoloration, Location: Rear Right Malleolus [ankle], Medial [t [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to ensure the appropriate care of indwelling, urinary catheter equipment for one Resident (R19) of three residents reviewed for catheter care, resulting in the potential for contamination of the equipment with infectious organisms and urinary tract infection. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. R19 was admitted on [DATE] and had diagnoses including diabetes and urethritis (bacterial or viral infection causing swelling and irritation of the urinary tract). Review of R19's quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed he was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for dressing, putting on/taking off footwear, and all mobility including rolling left to right, sitting to lying, lying to sitting, chair/bed-to-chair transfers and wheelchair mobility. Further review of the MDS assessment revealed R19 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he was cognitively intact. An observation on [DATE] at 2:49 p.m. revealed R19 lying in bed with catheter tubing leading from under the left side of R19's bed sheet to a dependent drainage bag hooked on the lower, left portion of the bed frame. The drainage bag was inside a dark blue, vinyl cover and the tubing leading directly from the bag was observed to be looped down away from the bag, with approximately three inches of the tubing resting directly on the floor before leading upward toward the Resident. Clear, yellow urine was observed in the tubing. An observation on [DATE] at 11:30 a.m. revealed CNA N and two unidentified students enter R19's room. CNA N informed R19 they were going to prepare him for transport to an outside appointment with his Urologist. Upon preparing for R19 to be transferred to a wheelchair, CNA N placed a clear, plastic cylinder directly on the floor beneath the drainage bag hooked to the right, lower portion of R19's bed frame. CNA N removed the bag from the dark blue cover and proceeded to empty amber colored urine from the bag. Upon emptying the bag, CNA N replaced the drainage spout in the holder on the outside of the bag and reported she knew she was supposed to disinfect the spout before replacing it but she did not have access to alcohol swabs therefore she could not disinfect the spout. CNA N placed the bag on the end or R19's mattress near his right lower leg. The bag was observed to fall to the floor while R19 was readied to be transferred using a total mechanical lift. At that time, CNA NN entered the room to relieve CNA N, who left the room with the uncovered catheter bag and tubing leading from the bag toward the Resident, resting directly on the floor. Upon walking to the right side R19's bed, CNA NN saw the drainage bag laying on the floor. CNA NN was observed picking up the bag from the floor, placing the bag in the dark blue cover and hooking the bag on R19's right lower bed frame. During an interview immediately following the observation, CNA NN reported catheter drainage bags and tubing should always be kept off the floor to reduce the risk of infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at approximately 2:00 p.m., Nurse Manager, Registered Nurse (RN) O, reported standards of practice are for catheter drainage bags and tubing to be positioned so no portion touches the floor. RN O stated allowing drainage bags and tubing to rest directly on the floor poses a risk of infection. RN O was asked if disinfecting the drainage spout was necessary after emptying urine. RN O reported the drainage spout should be wiped with an alcohol swap after emptying the urine from the bag to reduce bacterial buildup and the risk bacteria could enter the bag and tubing. Review of the facility polity titled Catheter Care, dated [DATE], revealed the following, in part: It is the policy of this facility to ensure that resident with indwelling catheters receive appropriate catheter care . Review of the Centers for Disease Control and Prevention (CDC) Guideline for Prevention of Catheter-Associated Urinary Tract Infection (CAUTI): Summary of Recommendations, updated [DATE], revealed the following, in part: Proper Techniques for Urinary Catheter Maintenance . Do not rest the bag on the floor .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on observation, interview and record review, the facility failed to assess respiratory status for residents receiving as needed respiratory medications and supplemental oxygen according to professional standards of practice for one Resident (R168) of one resident reviewed for respiratory care. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. R168 was admitted on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and dependence on supplemental oxygen. An observation on 5/19/2024 at 2:11 p.m. revealed R168 lying in bed wearing a nasal cannula with tubing attached to a portable oxygen concentrator positioned on the floor next to the Resident's nightstand. The oxygen concentrator was running and set to deliver two liters (2L) of oxygen per minute. A nebulizer was observed to be sitting on top of R168's nightstand, with tubing, medication cup and mouthpiece attached. R168 reported he used the supplemental oxygen continuously and only used the nebulizer when he was feeling short of breath. Review of R168's Admission & Re-Admission Evaluation - V5, dated 5/17/2024 at 3:47 p.m. (Central Daylight Time [CDT]) and locked on 5/20/2024 at 11:40 a.m. CDT, revealed R168's oxygen saturation on 5/17/2024 at 3:54 p.m. CDT, was 90%. R168 was assessed as having abnormal lung sounds with wheezing in the right and left upper lobes and diminished lung sound in both bases, a productive cough, shortness of breath upon exertion and at rest, and in need of oxygen therapy. It was noted, the Respiratory Care Plan was not triggered in the evaluation. Review of R168's May 2024 Medication Administration Record (MAR), accessed on 5/22/2024 at 7:57 a.m., revealed the following: Benzonatate [cough medicine] Oral Capsule 100 MG [milligram] . Give one capsule by mouth every 4 hours as needed for COPD, coughing. There was no order date listed on the MAR. Further review revealed the medication was administered to R168 on 5/18/2024 at 12:16 p.m. CDT and again on 5/21/2024 at 5:43 p.m. CDT. Guaifenesin [medication to loosen chest congestion] Oral Syrup . Give 10 ml [milliliter] by mouth every 4 hours as needed for cough [related to] COPD. There was no order date listed on the MAR. Further review revealed the medication was administered to R168 on the following dates: 5/17/2024 at 5:22 p.m. CDT, 5/18/2024 at 12:15 p.m. CDT, 5/20/2024 at 7:51 p.m. CDT, and 5/21/2024 at 5:43 p.m. CDT. Albuterol Sulfate Inhalation Nebulization Solution [medication used to treat wheezing and shortness of breath] (2.5MG/3ML) 0.083% . 1 dose inhale orally via nebulizer every 4 hours as needed for COPD. There was no order date listed on the MAR. Further review revealed the treatment was administered to R168 on the following dates: 5/22/2024 at 8:46 a.m. CDT, 5/23/2024 at 3:30 a.m. CDT and 12:18 p.m. CDT, 5/27/2024 at 12:01 p.m. CDT, 5/28/2024 at 11:42 a.m. CDT, and 5/29/2024 at 3:52 a.m. CDT. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R168's Electronic Medical Record (EMR) from the date of admission on 5/17/2024 through 5/29/2024 at 8:16 a.m., including assessments, progress notes, vital signs and the May 2024 MAR and May 2024 Treatment Administration Record (TAR), revealed no respiratory assessments or documented oxygen saturation levels for R168 after the initial assessment on 5/17/2024. During an interview on 5/29/2024 at 8:16 a.m., Registered Nurse (RN) K and RN J both reported respiratory assessments are a standard of practice when residents are administered as needed respiratory medication. A review of R168's record with RN K and RN J at that time revealed no respiratory assessments, including measurement of R168's oxygen saturation and lung sounds were documented before or after the administration of the albuterol sulfate nebulizer treatments, guaifenesin syrup or benzonatate capsules. RN K reported the importance of respiratory assessments before and after as needed respiratory medication was to assess the efficacy of the medication and to determine if further treatment is necessary. Review of R168's care plan with RN K and RN J revealed no focus area, measurable goals or interventions related to R168's primary diagnoses of COPD, use of continuous oxygen or use of as needed respiratory medications. Both RN K and RN J reported R168's care plan should include a focus area for COPD to outline the risk of respiratory complications and what interventions should be used to decrease the risk. Review of the facility policy titled Care Plan - Baseline, dated 8/25/2023, revealed the following, in part: It is the policy of the facility to develop a baseline plan of care to meet the resident' immediate health and safety needs for each resident within forty-eight (48) hours of admission. Review of the facility policy titled Oxygen Administration, dated 9/01/2019, revealed no procedure for respiratory assessment, including oxygen saturation measurement, after the administration of supplemental oxygen.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 This citation pertains to intakes MI00141835, MI00142802, and MI00142093. Based on observation, interview, and record review, the facility failed to provide adequate nursing staff to provide quality care and services. This deficient practice resulted in extended call light wait times with the potential for lack of care to meet resident's needs amongst any/all 73 residents. Findings include: (All times are in Eastern Daylight Time) A review of multiple complaints reported to the State Agency included allegations that there was not enough staff to consistently provide activities of daily living (ADL) including bathing, toileting, and oral care for residents, and not responding to call lights in a timely manner to provide appropriate care to meet resident's needs. Resident #53 (R53) On 5/19/24 at 2:15 PM, an interview with R53's resident representative (RR) was conducted. The RR stated R53 was not getting her soiled linens changed as needed when her call light was put on. R53 stated she felt embarrassed when the pink pad on the chair was not changed when it appeared dirty. R53's RR also stated that she felt the facility was short staffed, and it was unfortunate for those less self-sufficient than R53. Resident #10 (R10) A review of a grievance filed on 3/1/24 revealed she had gone into the bathroom at 8:20 PM to get ready for bed. Rang her call light. No one ever came so she turned it off and went into her room and turned that one on. Staff came in 25 minutes later and said that they would be back after shutting the light off, and never came back. During an interview with R10 on 5/20/24 at approximately 5:00 PM, R10 stated this made her feel uncared for and a nuisance to staff. A review of call light logs attached to R10's grievance indicated wait times of 32 minutes 28 seconds for the bathroom, and 25 minutes 6 seconds for R10's room. Resident #37 (R37) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/19/24 at 3:08 PM with R37 and their representative, R37's representative stated she did not feel the facility was staffed appropriately, and her father had stated he had excessive wait times, leading to R37 to not be positioned, turned, toileted, or groomed timely. During the interview, R37 voiced extended call light wait times. Review of call light logs from 5/14/24 to 5/28/24 for R37's room (room [ROOM NUMBER]) indicated eight wait times of over 15 minutes, three wait times over 20 minutes, four wait times over 30 minutes, two wait times over 40 minutes, and two wait times over 60 minutes during this two week time period. These extended wait times for room [ROOM NUMBER] occurred between 5:00 PM and 7:00 AM. On 5/20/24 at 3:48 PM, during resident council meeting, C1 (confidential resident #1) voiced that they had waited an hour and a half for a call light to be answered. C1 stated that long waits for call lights happened after 2:00 PM daily. Resident council members (10 in attendance) agreed that there is a lack of staff from 2:00 PM on every day. This Surveyor attempted to conduct interviews with three day and four evening CNAs (Certified Nursing Assistant) and nursing staff regarding any staffing issues but they would not speak on topic due to fear of losing their jobs. Review of the facility's Call Light Accessibility and Timely Response policy, read in part Staff members that see or hear an activated call light are responsible for responding, regardless of assignment. Per email correspondence with NHA (Nursing Home Administrator) on 5/29/24 at 2:15 PM regarding call light times, Call lights are to be answered within 15 minutes. There are instances where staff forgot to turn call lights off and we also encourage staff to leave the lights on if they cannot resolve the requests. We do room rounds and ensure residents requests are responded to timely. room [ROOM NUMBER] showed extensive call light response times.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41978 Based on observation, interview, and record review, the facility failed to ensure the administration of an incorrect dose of insulin was documented and the attending physician notified for one Resident (R18) of two residents reviewed for insulin administration, resulting in the potential for uncontrolled glucose levels and future orders for insulin dosages adjusted based on incorrect documentation. Findings include: An observation on 5/22/2024 at 9:20 a.m. revealed Registered Nurse (RN) TT preparing to administer 36 units of Lantus Solostar 100 units/milliliter (ML) (long-acting insulin pen) into the back of R18's left upper arm. After cleansing R18's skin with an alcohol pad, RN TT proceeded to insert the needle into R18's upper arm by holding the insulin pen like a dart, with her thumb and fingers holding the pen near the lower end of the pen, just above where the needle attaches to the pen. Once the needle was embedded in R18's arm, RN TT walked her fingers up the pen to place her right thumb on the injection button at the opposite end of the pen from the needle. The pen, with the needle embedded in R18's left upper arm was observed to be moving around and was not held steady by RN TT. Once RN TT had her right thumb on the injection button, she proceeded to press the button to deliver the dose of insulin. RN TT did not have a secure grip on the pen and while pressing the injection button she released pressure and the safety mechanism on the needle engaged. RN TT continued to press the injection button and the reported 10 units of the 36 units dialed to administer had not been delivered to R18 and remained in the pen, as observed by this surveyor. Immediately after the observation, RN TT returned to the medication cart, placed a new needle on the pen and wasted the 10 units of Lantus that had not been administered to R18. RN TT then dialed up the pen to 10 units. RN TT reentered R18's room and prepared to administer the 10 units of insulin into the back of R18's right arm. After cleansing with an alcohol pad, RN TT inserted the needle into R18's right arm by holding the insulin pen like a dart, with her fingers and thumb holding the pen near the lower end of the pen just above the needle, as previously observed. Once the needle was inserted into R18's arm, RN TT then walked her fingers up the pen to place her thumb on the injection button. RN TT proceeded to administer the insulin by pressing the injection button. RN TT did not hold the pen steady, and the insulin pen was observed to be moving around while she pressed on the injection button. RN TT was again observed to be struggling with the pen while pushing the injection button before stating only five units of the 10 units of insulin dialed up was administered. RN TT returned to the medication cart and reported she is unsure why the insulin pen stopped short of delivering the full dosage. RN TT then replaced R18's insulin pen inside the medication cart and began preparing medications to be administered to another resident. Review of R18's May 2024 Medication Administration Record (MAR) revealed RN TT signed she administered the full 36-unit dose of Lantus Solostar 100 units/ML to R18 on 5/22/2024 at 7:00 a.m. CDT (Central Daylight Time). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Kingsford	1225 Woodward Avenue Kingsford, MI 49801

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at approximately 2:30 p.m., the Director of Nursing (DON) reported he was unaware R18 did not received his full dose of long-acting insulin earlier that morning as observed. The DON stated facility procedure is to alert the attending physician when medication errors occur and to assess the Resident for any ill-effects of the error. When asked if RN TT should have documented she administered the full dose of Lantus 36 units when R18 only received 31 units, the DON stated RN TT should have notated on R18's MAR and in a progress note the correct amount administered to provide an accurate account of R19's medication administration. The DON reported he would follow-up on the incident. Review of R18's Electronic Medical Record (EMR), on 5/28/2024 at 3:44 p.m., revealed no documentation or physician notification regarding R18 receiving the incorrect dose of insulin on 5/22/2024.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41978 This citation pertains to intakes MI00141709 and MI00142802. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of 5% or less, with 3 medication errors observed of 35 opportunities, resulting in a medication error rate of 8.57%. Findings include: All times recorded in Easter Daylight Time (EDT), unless otherwise noted. An observation on 5/22/2024 at 9:59 a.m. revealed Registered Nurse (RN) TT preparing medications to be administered to Resident 19 (R19). RN TT pulled R19's packet of Keppra (anti-convulsant medication) 500 mg (milligram) tablets from the medication cart and place one tablet in a medication cup containing R19's other scheduled medications. After preparing all R19's scheduled, oral medication, RN TT was observed entering R19's room and assisted R19 with taking the medications. RN TT then performed a finger stick point of care blood glucose test with a result of 375 mg/dL (milligrams per deciliter). Immediately following the observation, RN TT was observed going back to the medication cart and prepared 38 units of Toujeo Max Solostar (long-acting insulin) 300 units/milliliter and 10 units of Humalog (fast-acting insulin) injection solution 100 units/ml to administer to R19. RN TT reentered R19's room and administered the Toujeo Max Solostar 38 units into R19's left upper arm. After pushing the injector button on the pen to administer the insulin, RN TT withdrew the needle from the Resident after 3 seconds. RN TT then administered the Humalog solution 10 units using an insulin needle into R19's left upper arm and after pushing the plunger to administer the insulin, withdrew the needle from R19's arm after 3 seconds. Immediately following the observation, RN TT was asked how long was appropriate to hold the insulin needles in place after administering the insulin to which she answered, five seconds. Review of R19's May 2024 Medication Administration Record (MAR), while reconciling R19's ordered medications with medications administered during the observation at 9:59 a.m., revealed the following order: levetiracetam (Keppra) oral tablet 1000 MG (milligram) Give 1000 mg by mouth two times a day for seizures. During an interview on 5/29/2024 at 8:00 a.m., Nurse Manager, RN L was asked what the appropriate times were for holding insulin needles in place to ensure the administration of the full dose insulin. RN L reported she was unsure as she had not worked the floor in a while. On 5/29/2024 at 8:09 a.m., RN L reported she contacted the pharmacy for the insulin manufacturer's instructions and found Humalog solution should be held in place for five seconds; and Toujeo Max Solostar should be held in place for five seconds. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Medication - Insulin Administration, revised 2/12/2024, revealed the following, in part: With the plunger depressed, keep the needle in the skin for the length of time specified per manufacturer's guidelines . Review of the facility policy titled, Medication Administration, dated 8/07/2023, revealed the following, in part: Medications are administered in accordance with the following rights of medication administration: . Right dose . Procedure: Open MAR to resident record and review physician medication order against medication label . remove medication from cart. Compare MAR with medication label for accuracy .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 13791 Based on observation and interview, the facility failed to ensure the dietary department was provided with sufficient and properly trained staff to carry out the functions and duties of the nutritional services department. This deficient practice has the potential to result in inadequate nutrition for all 73 residents. Findings include: (All reported times are in EDT) On 5/19/24 at approximately 3:45 PM, an interview with Kitchen Manager (KM) A was conducted. It was learned KM A had not completed the Certified Dietary Manager's (CDM) course, nor had credentials in food service sanitation, i.e. ServeSafe or Certified Food Service Manager (CFM). KM A stated she had completed about one half of the CDM coursework. At approximately 4:40 PM an interview was conducted with Registered Dietitian (RD) E who stated his responsibility was for clinical assessments and interventions, and did not have any role in the kitchen functions. On 5/21/24 at approximately 8:15 AM, an interview was conducted with KM A and it was learned the facility had a corporate registered dietitian (F) who consulted via phone but had not been to the facility to assist in training KM A for kitchen sanitation, menu and recipe adherence or other kitchen duties. The FDA Food Code 2017 states: Knowledge 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (A) Complying with this Code by having no violations of PRIORITY ITEMS during the current inspection; Pf (B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM;Pf or (C) Responding correctly to the inspector's questions as they relate to the specific FOOD operation. The areas of knowledge include: (11) Explaining correct procedures for cleaning and SANITIZING UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT; 2-102.12 Certified Food Protection Manager (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. (B) This section does not apply to certain types of FOOD ESTABLISHMENTS deemed by the REGULATORY AUTHORITY to pose minimal risk of causing, or contributing to, foodborne illness based on the nature of the operation and extent of FOOD preparation. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2-102.20 Food Protection Manager Certification. (A) A PERSON IN CHARGE who demonstrates knowledge by being a FOOD protection manager that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for Food Protection-recognized accrediting agency as conforming to the Conference for Food Protection Standards for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with 2-102.11(B). (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection recognized accrediting agency as conforming to the Conference for FOOD Protection Standards for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2 102.12.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observations, interview and record review, the facility failed to ensure that menus met the nutritional needs of the residents, were followed and prepared according to the recipes, and were reviewed and approved by a Registered Dietitian. This deficient practice has the potential to result in nutritional deficiencies to all 73 residents. Findings include: (All reported times are in EDT). On 5/20/24 at approximately 8:00 AM, the full current cycle of menus was requested from the facility. At approximately 9:00 AM four weeks of menus were provided and reviewed. The review noted there was no evidence of a Registered Dietitian's (RD) review. On 5/20/24 at approximately 2:15 PM, an interview was conducted with Kitchen Manager (KM) A. It was learned during this interview that the menus were not reviewed and formally approved by the facility's corporate RD, and furthermore, changes made to the menus in the facility were not approved by the RD. On 5/20/24 at approximately 12:45 PM, the noon meal was observed to be served. The main component was identified as Mostaccioli and was being served from the steam table. At this time an interview was conducted with KM A and asked if the Mostaccioli had any meat. KM A stated No. KM A then stated the protein source for the dish was sourced through the cheese. A review of the recipe for the Mostaccioli was conducted and learned that the dish required five pounds of cottage cheese for every 50 servings. On 5/21/24 at approximately 8:30 AM, an interview was conducted with Cook G, who had made the Mostaccioli the day before. Cook G stated that he had used about two and a half pounds of cottage cheese for the dish that was meant to serve the 74 residents. When asked if all the Mostaccioli had been served, Cook G stated No and indicated that about a third of the pan had not been served. Cook G stated he was not aware of the recipe requirements for the Mostaccioli. A review of the facility's Menu Policy dated 10.2022 with the latest revision date of 05.2023 revealed the following: Compliance Guidelines: Corporate Menu 1. The corporate menus are planned by the Corporate Registered Dietitian. a. The menu can be altered at the facility level with the guidance and approval of the facility RD and or corporate RD. Menu changes and substitutions must be signed off by the RD. b. The menu planned are a 4-week cycle and menus are updated seasonally by the corporate RD. c. Monitoring the resident satisfaction is ongoing, and changes will be made as needed. d. Menu updates are sent to each facility electronically, by the corporate RD. Spreadsheets and recipes are included in the electronic transmission of the updated menu. Facilities who use tray card, will use. e. Spreadsheets to determine daily food production. Facilities who use tray tickets, may use the production guide for this purpose. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	40383 On 5/20/24 at 12:48 PM, the lunch meals were observed to include mostaccioli, garlic bread, green beans, and fruited jello. The mostaccioli appeared to have no meat and had cottage cheese or ricotta cheese, but only four to five pearls of cottage cheese per serving visible. The recipe for the mostaccioli was requested to investigate the protein content of the mostaccioli entree. During the initial tour on 5/19/24 at 2:54 PM, Resident # 22 (R22) stated she had a healing below the knee amputation, and she needed to be fitted for a prosthesis. She said she knew she needed protein to continue with the healing process. However, she said, There is bad food here with very little protein. I have gained weight by eating crap here. She showed me protein supplements that she had ordered because the facility was not serving enough protein. The Electronic Medical Record (EMR) revealed a Minimum Data Set (MDS) assessment dated [DATE] listing the admitted for R22 as 8/26/23 with diagnoses including primary medical condition of amputation, anemia, and diabetes. The MDS also revealed a Brief Interview of Mental Status (BIMS) assessment score of 15/15 indicating R22 was cognitively intact. On 5/20/24 at 1:37 PM, R22 called this surveyor into her room to look at her lunch tray. Her diet slip indicated R22 was to receive a Regular diet with a request for mashed potatoes. Her plate contained the requested mashed potatoes along with mostaccioli, green beans, garlic bread and fruited jello. R22 said, Look, I told you the other day we do not get protein. There is no protein in this meal. I have to order my own protein powder and supplements. They do not serve protein. During an interview on 5/20/24 at 2:10 PM, Dietary Cook (Staff G) stated he made the mostaccioli and indicated cottage cheese was an ingredient. When asked about the amount of cottage cheese used Staff G showed this surveyor the five-pound container and said he used two pounds but did not measure but just dumped some in. Staff G stated he made a deep steam table pan of the entree and another cook (Staff B) served the mostaccioli on the line. Staff B was asked about the use of left over items after the meal was served and stated today they had saved about 5 portions in case there was a new admit, or a resident wanted another serving. After this they had about one quarter (of the deep steam table pan of mostaccioli) left. There was no record of usage or amount made, Staff B was only able to estimate along with Staff G who produced the meal. On 5/20/24 at 2:37 PM, Dietary Manager (Staff A) reviewed the recipe for the lunch entree titled Mostaccioli No Meat. The recipe indicated five pounds of cottage cheese was needed for 50 servings. The facility had approximately 73 residents and of the batch produced one quarter of the mostaccioli was left along with five additional servings reserved for requests. Staff A confirmed the production cook (Staff G) does not always follow the recipes. During an interview on 5/22/24 at 11:06 AM, the local Consulting Registered Dietitian (RD) E discussed the facility diets, menus and the recipes being served. RD E stated he had also worked with R22, and she had brought up the issue of inadequate protein in the facility meals. RD E said, If we did not do the recipe right, we did not have enough protein.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 13791 Based on observation, interview and record review the facility failed to follow menu recipes to ensure that the nutritional value of the items was met. This deficient practice has the potential to result in nutritional deficiencies to all 73 residents of the facility. Findings include: (All times reported in EDT) On 5/20/24 at approximately 12:45 PM, the noon meal was observed to be served. The main component was identified as Mostaccioli and was being served from the steam table. At this time an interview was conducted with KM A and asked if the Mostaccioli had any meat. KM A stated No. KM A then stated the protein source for the dish was sourced through the cheese. A review of the recipe for the Mostaccioli was conducted and learned that the dish required five pounds of cottage cheese for every 50 servings. On 5/21/24 at approximately 8:30 AM, an interview was conducted with Cook G, who had made the Mostaccioli the day before. Cook G stated that he had used about two and a half pounds of cottage cheese for the dish that was meant to serve the 73 residents. When asked if all the Mostaccioli had been served, Cook G stated No and indicated that about a third of the pan had not been served. Cook G stated he was not aware of the recipe requirements for the Mostaccioli. On 5/20/24 at approximately 1:30 PM an interview was conducted with KM A regarding production records. KM A stated the facility did not maintain any records related to the amount of food used for any meals and therefore could not verify recipes were being followed related to amounts of protein and other ingredients necessary to maintain nutritional status of the residents. A review of the facility's Menu Policy dated 10.2022 with the latest revision date of 05.2023 revealed the following: Compliance Guidelines: Corporate Menu 1. The corporate menus are planned by the Corporate Registered Dietitian. a. The menu can be altered at the facility level with the guidance and approval of the facility RD and or corporate RD. Menu changes and substitutions must be signed off by the RD. b. The menu planned are a 4-week cycle and menus are updated seasonally by the corporate RD. c. Monitoring the resident satisfaction is ongoing, and changes will be made as needed. d. Menu updates are sent to each facility electronically, by the corporate RD. Spreadsheets and recipes are included in the electronic transmission of the updated menu. Facilities who use tray card, will use. e. Spreadsheets to determine daily food production. Facilities who use tray tickets, may use the production guide for this purpose.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility failed to ensure residents received diets as prescribed by a physician for one of three residents reviewed for therapeutic diets (Resident #25) in a sample of 18 Residents. This deficient practice resulted in the potential for health complications. Findings include: (All reported times are in Eastern Daylight Time.) On 5/19/24 at 3:23 PM, Resident # 25 (R25) was observed in her room sitting in her recliner, while the remainder of her lunch tray was positioned on the bedside table. The tray had 25% of the ham uneaten, 25% of the cheesy potatoes remained uneaten and 25% of the caramel bread pudding remained uneaten. The lunch diet slip read DIET: Menu 2 Gram Sodium Diet Order: Cardiac Regular Texture . R25 said the food is always the same. The Electronic Medical Record (EMR) face sheet revealed R25 was originally admitted to the facility on [DATE] with diagnoses including heart failure, muscle wasting, heart attack, atherosclerotic heart disease, chronic kidney disease, and high blood pressure. The EMR contained a current Physician diet order with start date of 3/12/24 listed as: Cardiac diet, Regular texture, Thin consistency. The EMR also included a care plan for R25 with a focus of Alteration in cardiac function r/t (related to) anemia, edema, hyperlipidemia, and CAD (coronary artery disease). Date Initiated: 01/09/2024. This care plan did not include dietary interventions. Another care plan included a focus of At risk for altered nutrition r/t heart disease, anemia, high BMI (body mass index) with no desire to participate in a weight loss program. 4/2024- wt (weight) stable. Date Initiated: 01/09/2024. Interventions for this nutrition care plan included: cardiac diet per order . Date Initiated: 01/09/2024 During an interview on 5/20/24 at 2:37 PM, the Dietary Manager (Staff) A discussed the diet of R25 DIET: Menu 2 Gram Sodium Diet Order: Cardiac Regular Texture . Staff A explained while the diet order from the physician was a Cardiac Regular the corporate software program the dietary department used was a 2 gram sodium diet as the corporate software program did not have a Cardiac Regular diet. When Staff A was asked what the difference was between these two diets she was not sure. When the observations of R25 receiving ham, cheesy potatoes and caramel bread pudding were discussed, Staff A said a cardiac diet 2 gram sodium should not get cheese or ham. Staff A was asked the difference between a no added salt diet, a 2 gram sodium diet and a cardiac diet, and replied these diets were all served the same according to the corporate software that was used. This surveyor suggested looking at a reference such as the facility Diet Manual. The facility did not have a Diet Manual reference guide to define what foods were included or excluded in any diet a physician would prescribe. Staff A stated the facility corporate software system could only print a 2 gram sodium diet and could not print the diet as prescribed by the physician of a cardiac diet. When Staff A was asked if the menus had been reviewed by a Registered Dietitian (RD), no evidence could be provided that the menus had been reviewed. There were no signatures or other evidence of a review. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 5/20/24 at 2:58 PM, the Corporate Dietitian, (RD) F stated she would send over (via email) the menus signed and said, I never was asked to sign the menus. When asked about the physician order for a cardiac diet, RD F said 2 gram sodium diets were used. While a standard cardiac diet would be low fat, low sodium, RD F stated they did not want the dietary departments for all of the corporate facilities to have to buy multiple things for different diet types so we just use similar items like 2% milk across the board. RD F stated, We don't have a diet manual . We were using the ADA (American Dietetic Association's Diet Manual) but then we did not want to use skim milk (for the low fat and cardiac diets) . I am writing the diets now. It is a work in progress as I am working on it. During an interview on 5/22/24 at 11:06 AM, the local Consulting Dietitian (RD E) discussed the diets the facility was serving. When RD E discovered the corporate software substituted a 2 gram sodium diet instead of the cardiac diet which was ordered by the physician, RD E stated, We have issues. A cardiac diet is not the same as a 2 gram sodium (diet). He was unaware the corporate dietitian had failed to choose and provide a diet manual for the Dietary Manager to reference. The facility policy titled Menu Policy dated as last revised 5/2023 read in part, .a. The corporate menus are planned by the Corporate Registered Dietitian. b. The menu can be altered at the facility level with the guidance and approval of the facility RD and or corporate RD. Menu changes and substitutions must be signed off by the RD . Diet order: a. Nursing staff will enter in the diet order upon admission, the diet order will be electronically transmitted to RDS (facility corporate software program). The menus associated with each diet order will be assigned electronically.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 13791 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among any and all 73 residents. Findings include: (All times reported in EDT) On 5/20/24 at approximately 12:10 PM, Cook B was observed preparing the steam table with hot food, including a pan of Mostaccioli. Cook B was asked if the hot food was prepared to be served and if the temperature of the foods had been measured. Cook B responded yes. Using a Thermapen metal stem digital thermometer, the Mostaccioli was measured to have temperatures of 119 F, 122 F and 128 F. An interview with Cook B followed and was asked what temperature she had measured. Cook B replied she had measured 178 F. Cook B was requested to demonstrate the procedure used to measure the temperature of the Mostaccioli. Cook B , using a metal stem digital thermometer, placed it toward the back of the pan and pushed the stem down to within a half inch of the bottom. Cook B reported a temperature of 168 F. Cook B was then requested to take additional measurements in various locations within the product. Cook B reported temperatures between 120 F and 128 F. The FDA Food Code 2017 states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401. 11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above On 5/19/24 at approximately 1:20 PM, kitchen staff were observed to be doing dish washing activities in the dish room, using the mechanical high temperature dish machine. Cook B and Dietary Aide (DA) G were present in the dish room and were asked how the sanitizing cycle was monitored. Cook B produced a digital maximum registering thermometer (MRT) and stated this device was used to monitor the sanitizing cycle. At approximately 1:30 PM, following four racks of dishes being placed through the machine, the MRT was placed on a rack and allowed to run through the machine's cycle. Once removed the MRT reported a temperature of 158 F. DA G was asked what the significance of the reported temperature was, who stated it was too low. Cook B then stated the machine had not been working correctly since it had been installed in the beginning of February. During this same observation period, DA G was observed on the clean side of the dish machine, pulling the trays out the end before the tray had completed its entire cycle. The nose of the tray was only about 2 exposed from the end of the inside compartment, when DA G would use a blue tool to pull the tray out which did not allow the dishes to be fully exposed to the sanitizing cycle of the machine. The FDA Food Code 2017 states: 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions. (B) A WAREWASHING machine's conveyor speed or automatic cycle times shall be maintained accurately timed in accordance with manufacturer's specifications. 4-703.11 Hot Water and Chemical. After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (A) Hot water manual operations by immersion for at least 30 seconds and as specified under S 4-501.111; P (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under SS 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71oC (160oF) as measured by an irreversible registering temperature indicator; P or On 5/19/24 at approximately 4:00 PM, a fire in the mechanical dish machine was identified and extinguished, leaving the machine inoperable. An interview with the Maintenance Manager (MM) E was conducted. MM E stated the dish machine had not been working properly since it had been installed in February, and the service representatives had been in multiple times every week since its installation. On 5/19/24 at approximately 4:30 PM, an interview with KM A was conducted. KM A acknowledged the facility did not have a working dish machine and all dishes were having to be washed, rinsed and sanitized in the three compartment sink (3-C sink). The 3-C sink was not located in the dish room, rather, was located on the south wall of the kitchen, adjacent to the food preparation and serving areas. KM A was requested to demonstrate the proper use and testing of the 3-C sink. To demonstrate the testing of the sanitizing solution, KM A removed a piece of quaternary test strip and placed it in the sanitizing solution of the sink. KM A reported a 200 parts per million (PPM) concentration. When compared to the color scale on the package, the actual result was 0 ppm. KM A was not aware of the chemical being used in the sink was Lactic Acid and required a different test strip. Once described, KM A located the proper test strip for the chemical being used. KM A stated she had not been trained or educated about the sanitizing chemicals or the proper method to test the solution to ensure the proper concentration was present. The FDA Food Code 2017 states: Knowledge 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (A) Complying with this Code by having no violations of PRIORITY ITEMS during the current inspection; Pf (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM;Pf or (C) Responding correctly to the inspector's questions as they relate to the specific FOOD operation. The areas of knowledge include: (11) Explaining correct procedures for cleaning and SANITIZING UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT; 2-102.12 Certified Food Protection Manager (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. (B) This section does not apply to certain types of FOOD ESTABLISHMENTS deemed by the REGULATORY AUTHORITY to pose minimal risk of causing, or contributing to, foodborne illness based on the nature of the operation and extent of FOOD preparation. 2-102.20 Food Protection Manager Certification. (A) A PERSON IN CHARGE who demonstrates knowledge by being a FOOD protection manager that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for Food Protection-recognized accrediting agency as conforming to the Conference for Food Protection Standards for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with 2-102.11(B). (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection recognized accrediting agency as conforming to the Conference for FOOD Protection Standards for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2 102.12. Observations of the use of the three compartment sink on 5/20/24 following the noon meal (approximately 12:30 PM to 1:30 PM) and again on 5/21/24 following the morning meal and noon meals, demonstrated the sink area was not equipped with adequate area for soiled dish storage and that of draining and drying the volume of dishes from the meals. Staff were placing towels on the floor to absorb excessive water from the draining of the dishes under temporary racks placed between the sink and the food preparation tables. Only 24 of flanking drain board was available on the soiled end of the sink and 36 available at the clean end of the sink. An interview was conducted with KM A on 5/20/24 at approximately 9:00 AM related to the lack of space for dish cleaning. KM A stated, while doing dishes, We are doing the best we can with what we have. The FDA Food Code 2017 states: 4-204.119 Warewashing Sinks and Drainboards, Self-Draining. Sinks and drainboards of WAREWASHING sinks and machines shall be self-draining. 4-204.120 Equipment Compartments, Drainage. EQUIPMENT compartments that are subject to accumulation of moisture due to conditions such as condensation, FOOD or BEVERAGE drip, or water from melting ice shall be sloped to an outlet (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that allows complete draining. On 5/20/24 at approximately 9:00 AM an interview was conducted with KM A related to cleaning of soiled dishes coming in from residents' rooms. KM A stated there was no alternative to that of bringing the soiled dishes through the food service and preparation area. KM A continued saying, they were going to utilize disposable containers, if that was okay with the State (agency). The FDA Food Code 2017 states: Preventing Contamination from Other Sources 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306 On 5/19/24 at approximately 2:10 PM, boxes of styrofoam cups were observed being stored in the storage room, known as the [NAME] Room. These food service items were stored directly below 4 cast iron sewer lines, located below the ceiling elevation in the room. The iron sewer pipes were not guttered or in any other way isolated to contain any leakage. An interview with MME was conducted on 5/20/24 at approximately 3:30 PM. MM E stated he was not aware the food service products had been stored below the sewer lines. The FDA Food Code 2017 states: 4-903.12 Prohibitions. (A) Except as specified in (B) of this section, cleaned and SANITIZED EQUIPMENT, UTENSILS, laundered LINENS, and SINGLE SERVICE and SINGLE-USE ARTICLES may not be stored: (1) In locker rooms; (2) In toilet rooms; (3) In garbage rooms; (4) In mechanical rooms; (5) Under sewer lines that are not shielded to intercept potential drips;

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 40383 During this annual survey process the survey team identified an immediate jeopardy for pressure ulcers due to the facility's failure to identify, completely and accurately assess, appropriately treat and implement interventions to prevent facility-acquired pressure injuries and promote healing and prevent worsening of existing pressure injuries. When the NHA was asked if the QAPI committee had addressed skin and wound issues, she could not show any evidence of documentation demonstrating performance improvement activities in this area. The NHA reviewed the QAPI committee minutes and could only find a mention of Other injuries which she thought could include pressure ulcers. When asked for additional information, the NHA said the Director of Nursing (DON) would have that documentation, but the QAPI minutes did not contain an analysis of data tracking and trending or system improvements to prevent or heal pressure ulcers. The facility provided the policy Quality Assessment and Process Improvement which was dated as issued 10/15/2018 with no recent review dates and unsigned blank areas indicating no approval by Administration or Medical Director. This policy read in part: . 4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: a. The written QAPI plan. b. Systems and reports demonstrating systematic identification, investigation, analysis. c. Documentation demonstrating performance improvement activities . 8 . b. Data will be collected in accordance with established procedures for the collection of such data, and will be used to develop and monitor goals. c. Goals will be established based on data, and will be monitored/evaluated in the QA Committee meetings. On 5/29/24 at 9:04 AM, the DON presented a binder on pressure injuries. The DON stated in January of this year there had been a skin sweep (all residents were assessed for skin injuries), education and audits for a few months. The binder was reviewed and revealed an undated education sign-in sheet and a policy. No education agenda was included. There were sheets on the skin sweep and audits of follow up, but there were no data analysis or action items. There were no totals indicating how many pressure ulcers or what stages or what issues were being addressed. When asked how many Residents had pressure ulcers in January or how the success of the education was measured, the DON and NHA did not respond. The DON stated he could pull that data together if it was needed. The DON could not produce data on tracking or trending of pressure ulcers for the months of January, February, March, April or even how many pressure ulcers were currently present in May. There was no evidence this topic had been reported to the QAPI committee or was a part of the QAPI program. The facility policy Quality Assessment and Process Improvement read in part: Quarterly meetings will be led by the facility Administrator, Medical Director, and DON, and will be attended with presentation and documentation provided by Corporate Quality department . It is the policy of the facility to meet weekly and monthly as outlined . The policy included a table of Required Minimum Meeting Schedule for Weekly/Monthly meetings. This table indicated pressure injuries would be discussed weekly with the Purpose of Topic-Specific QAPI Weekly/Monthly Meetings to be as follows: The topic-specific QAPI Meetings will be composed of staff related to the topic being addressed. The purpose is to: Review and analyze data related to the specific topic (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Identify developing trends Identify problem areas immediately where the facility has fallen below set goals Perform a Root Cause Analysis of identified concerns Brainstorm possible solutions Initiate a PDSA (Plan Do Study Act) Model to test possible solutions or, if a process error was identified as the Root Cause, a PIP may be more appropriate Discuss PDSA's that may have been ineffective, and determine if a possible process change is needed to improve the area of concern (PIP-Performance Improvement Project) Prioritize and organize identified PIP's for implementation Discuss PIP's and PDSA's to determine what further action should be taken During an interview on 5/29/24 at 8:57 AM, Regional Registered Nurse Clinical Consultant (RN) I stated there is not a weekly meeting (to discuss pressure ulcers) as stated in the Quality Schedule in the QAPI program. During an interview on 5/29/24 at 9:04 AM, the DON confirmed, We used to have a weekly meeting in January, February and March, but we are no longer meeting weekly. The facility policy Quality Assessment and Process Improvement read in part: . Program activities - a. All identified problems will be addressed. Considerations include, but are not limited to: i. High-risk, high-volume, or problem-prone areas. ii. Incidence, prevalence, and severity of problems in those areas. iii. Measures affecting resident health, safety, autonomy, choice, and quality of care. 49397 This citation pertains to intake # MI00142802. Based on observation, record review, and interviews the facility failed to administer its policies, practices, and procedures in a manner that displayed effective and efficient use of its resources to support the nursing staff with leadership resources when staffing needs were increased. This has the potential to affect the achievement and maintenance of the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include: (All reported times are in Eastern Daylight Time.) The complainant reported in part to the State Agency (SA) on 2/16/24 at 10:56 AM, when calling DON (Director of Nursing), after hours for guidance or emergency . under the influence of alcohol and sometimes not answering . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/19/24 at 2:00 PM it was noted that the DON was listed as the on-call resource. Registered nurse (RN) JJ reported that they had called the DON to alert him that the SA was in the building. The DON indicated he was unable to come in as he was 4 hours away at a dance recital. The Nursing Home Administrator (NHA) was also contacted and would not be able to come into the facility until the 5/20/24. Review of the (facility) job description of the Director of Nursing indicated a DON must be Able to respond to change productively and to handle additional tasks/projects as assigned and respond to unit needs on an on-call basis. Able to handle stressful and emergency situations of all types with tact and diplomacy. Demonstrates respect for coworkers and responds to the needs of residents by complying with attendance and punctuality policies. Reports for duty on all needed shifts. Respond to staffing needs appropriately to assure proper patient care. On 5/28/24 at 4:14 PM, the NHA was asked to provide the on-call policy for supervision and nursing staff. On 5/29/24 at 11:15 AM, the NHA reported they did not have an on-call policy for supervision and nursing staff. The NHA stated it was expected the DON and NHA were basically on call 24 hours a day. Staff were reluctant to discuss concerns of administration due to past actions and current concerns of retaliation with fear of losing their jobs. Confidential staff RR did report concern that they had called and asked for DON to come into the facility to help and were told no or ridiculed for calling on several occasions. RR stated administration was made aware of these incidents and had not acted upon them.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 49397 Based on interview and record review, the facility failed to conduct and document an annual facility wide assessment resulting in the potential for inadequate knowledge of the facility population's needs and potential for inadequate resources to care for any and all 73 residents in the facility. Findings include: (All reported times are in Eastern Daylight Time) On 5/21/24 at 11:24 AM, the Nursing Home Administrator (NHA) was asked for a copy of the Facility Assessment. The NHA provided a Facility Assessment with the previous ownership of facility on it. During an interview on 5/21/24 at 11:40 AM, the NHA stated the facility assessment had been reviewed, signed 10/16/23, and was current. The owner of the facility was not current. Review of the Facility Assessment section titled Minimum Data Set (MDS) Resident Population Profile was dated 10/28/21-10/27/22 and the Patient Population was dated 10/2022 which did not reflect the current resident population. On 5/29/24 at 12:00 PM, during follow up interview the NHA and Regional Clinical Resource nurse stated they were waiting to update the Facility Assessment until Centers for Medicare and Medicaid Services (CMS) had updated the facility assessment guidelines.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40383 Based on interview and record review, the facility failed to implement and maintain an effective, comprehensive, data-driven Quality Assurance & Performance Improvement (QAPI) program to develop and implement appropriate plans of action to correct identified quality deficiencies. This deficient practice resulted in a system failure in the skin and wound program for prevention and healing of pressure ulcers, which had the potential to affect all 73 residents in the facility. Findings include: (All reported times are in Eastern Daylight Time.) During an interview on 5/29/24 at 7:27 AM, the Nursing Home Administrator (NHA) stated the QAPI committee met monthly with the goal of looking for department projects, systems that needed to be put in place, and what needed to be done to improve. The NHA indicated each department head participated and reported on issues included in their areas. The NHA gave an example of a process improvement plan stating, We are doing inventory sheets. Another area the NHA mentioned was infection control stating, We are getting the (infection) book together and keeping up with policies. During this annual survey process the survey team identified an immediate jeopardy for pressure ulcers due to the facility's failure to identify, completely and accurately assess, appropriately treat and implement interventions to prevent facility-acquired pressure injuries and promote healing and prevent worsening of existing pressure injuries. When the NHA was asked if the QAPI committee had addressed skin and wound issues, she could not show any evidence of documentation demonstrating performance improvement activities in this area. The NHA reviewed the QAPI committee minutes and could only find a mention of Other injuries which she thought could include pressure ulcers. When asked for additional information, the NHA said the Director of Nursing (DON) would have that documentation, but the QAPI minutes did not contain an analysis of data tracking and trending or system improvements to prevent or heal pressure ulcers. The facility provided the policy Quality Assessment and Process Improvement which was dated as issued 10/15/2018 with no recent review dates and unsigned blank areas indicating no approval by Administration or Medical Director. This policy read in part: . 4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: a. The written QAPI plan. b. Systems and reports demonstrating systematic identification, investigation, analysis. c. Documentation demonstrating performance improvement activities . 8 . b. Data will be collected in accordance with established procedures for the collection of such data, and will be used to develop and monitor goals. c. Goals will be established based on data, and will be monitored/evaluated in the QA Committee meetings. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/29/24 at 9:04 AM, the DON presented a binder on pressure injuries. The DON stated in January of this year there had been a skin sweep (all residents were assessed for skin injuries), education and audits for a few months. The binder was reviewed and revealed an undated education sign-in sheet and a policy. No education agenda was included. There were sheets on the skin sweep and audits of follow up, but there were no data analysis or action items. There were no totals indicating how many pressure ulcers or what stages or what issues were being addressed. When asked how many Residents had pressure ulcers in January or how the success of the education was measured, the DON and NHA did not respond. The DON stated he could pull that data together if it was needed. The DON could not produce data on tracking or trending of pressure ulcers for the months of January, February, March, April or even how many pressure ulcers were currently present in May. There was no evidence this topic had been reported to the QAPI committee or was a part of the QAPI program. The facility policy Quality Assessment and Process Improvement read in part: Quarterly meetings will be led by the facility Administrator, Medical Director, and DON, and will be attended with presentation and documentation provided by Corporate Quality department . It is the policy of the facility to meet weekly and monthly as outlined . The policy included a table of Required Minimum Meeting Schedule for Weekly/Monthly meetings. This table indicated pressure injuries would be discussed weekly with the Purpose of Topic-Specific QAPI Weekly/Monthly Meetings to be as follows: The topic-specific QAPI Meetings will be composed of staff related to the topic being addressed. The purpose is to: Review and analyze data related to the specific topic Identify developing trends Identify problem areas immediately where the facility has fallen below set goals Perform a Root Cause Analysis of identified concerns Brainstorm possible solutions Initiate a PDSA (Plan Do Study Act) Model to test possible solutions or, if a process error was identified as the Root Cause, a PIP may be more appropriate Discuss PDSA's that may have been ineffective, and determine if a possible process change is needed to improve the area of concern (PIP-Performance Improvement Project) Prioritize and organize identified PIP's for implementation Discuss PIP's and PDSA's to determine what further action should be taken During an interview on 5/29/24 at 8:57 AM, Regional Registered Nurse Clinical Consultant (RN) I stated there is not a weekly meeting (to discuss pressure ulcers) as stated in the Quality Schedule in the QAPI program. During an interview on 5/29/24 at 9:04 AM, the DON confirmed, We used to have a weekly meeting in January, February and March, but we are no longer meeting weekly. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Quality Assessment and Process Improvement read in part: . Program activities - a. All identified problems will be addressed. Considerations include, but are not limited to: i. High-risk, high-volume, or problem-prone areas. ii. Incidence, prevalence, and severity of problems in those areas. iii. Measures affecting resident health, safety, autonomy, choice, and quality of care.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40383 Based on interview and record review, the facility failed to ensure that a Quality Assurance and Performance Improvement (QAPI) program committee was composed of the required committee members. This deficient practice resulted in the potential for ineffective coordination of medical care and delayed resolution of facility issues placing all 73 residents of the facility at risk for quality care concerns. Findings include: (All reported times are in Eastern Daylight Time.) During an interview on 5/29/24 at 7:27 AM, the Nursing Home Administrator (NHA) stated the QAPI committee met monthly and indicated each department head participated and reported on issues included in their areas. The NHA reviewed the Quality Assurance and Performance Improvement Committee Meeting Attendance Record sign in sheets for the required members and identified the following: - On 5/9/23, the QAPI meeting included signatures of the NHA, the Director of Nursing/Infection Preventionist, (DON/IP), and 6 other members but did not include the Medical Director. - On 6/19/23, the QAPI meeting included signatures of the NHA, the DON/IP, the Medical Director and only one other member (a representative from the Rehabilitation department). Only these four members were present, and no other department heads were present to report on issues included in their areas. - On 7/17/23, the QAPI meeting included signatures of the NHA, the DON/IP, the Medical Director and only one other member (the Pharmacy consultant). Only these four members were present, and no other department heads were present to report on issues included in their areas. - The quarters including November 2023, December 2023, January 2024 and February 2024, March 2024, April 2024) had no sign in sheets per the facility policy but were noted to have at least one meeting each quarter which included the required members typed on to the Quality Assurance and Performance Improvement (QAPI) Committee Agenda and Minutes. - No direct care staff were noted to be in attendance according to the facility policy on QAPI. In summary: - The sign in sheets for the quarter of 5/23, 6/23 and 7/23 revealed there was no meeting with required members. - There were no sign in sheets for the two quarters of 11/23, 12/23, and 1/24 and 2/24, 3/24, and 4/24 per the facility QAPI policy, only typed members names. - The sign in sheets indicated the QAPI committee did not consist of members from each department per the facility QAPI policy. (continued on next page)

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	235267	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Kingsford	1225 Woodward Avenue Kingsford, MI 49801

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- And the sign in sheets indicated no direct care staff were noted to be in attendance per the facility QAPI policy. The facility provided the policy Quality Assessment and Process Improvement which was dated as issued 10/15/2018 with no recent review dates and unsigned blank areas indicating no approval by Administration or Medical Director. This policy read in part: Quarterly QAPI meetings will be documented with Sign-In Sheet and Minutes. All Quarterly meetings should be attended by members of the Direct Care Staff in order to provide representation, feedback, and insight from all levels of staff. Quarterly meetings will be led by the facility Administrator, Medical Director, and DON, and will be attended with presentation and documentation provided by Corporate Quality department .The QA (Quality Assurance) Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The director of nursing services; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which must be the administrator, or other individual in a leadership role; iv. The infection control and prevention officer, or designee . QAPI Committee Framework QAPI Committee Members: QAPI Committee will consist of members from each department. Effective teamwork among all facility departments is a core component of QAPI . *At a minimum, the Quarterly QAPI Committee should include the Director of Nursing, a physician designated by the facility, at least 3 other members of the facility's staff at least one of which must be the administrator or other individual in a leadership role, and the Infection Prevention and Control Officer or designee.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13791 Based on observation and interview, the facility failed to maintain or ensure proper maintenance was provided on essential equipment in the kitchen. This deficient practice had the potential to result in equipment not being operational and contributing to unnecessary risks to staff and residents. Findings include: (All times reported in EDT) On 5/19/24 at approximately 2:30 PM, the floor under the three compartment sink and under the refrigerator near the south wall of the kitchen, were observed covered in water. An interview was conducted with Cook C at this time and it was learned the water was attributed to the drain from the three compartment sink overflowing. Cook C stated this has been an ongoing problem when the drains are opened from any of the compartments on the sink, the drain into the floor cannot handle the flow from even one of the sinks, individually. On 5/19/24 at approximately 4:45 PM, an interview was conducted with Kitchen Manager (KM) A regarding the water on the floor. KM A confirmed the statement from Cook C that the origin of the water on the floor was the three compartment sink when the drains from the sinks are opened. On 5/21/24 at approximately 9:50 AM, an interview with Maintenance Manager (MM) E was conducted related to the kitchen drain. MM E reiterated this issue has been ongoing for a long time. On 5/19/24 at approximately 3:30 PM, a smoke odor was noted while sitting at the nurses' desk on the first floor. Upon investigation, it was found that the mechanical dish machine, in the dish room of the kitchen, had over heated within the washing compartment and created a [NAME] of smoke and steam. A kitchen staff person had used a dry chemical extinguisher to eliminate the risk of spread of fire. At approximately 4:30 PM, an interview with MM E was conducted related to the dish machine. MM E stated the machine had not worked properly since it had been installed in early February. Furthermore, MM E stated that service representatives had been servicing the machine multiple times per week due to machine failures. On 5/20/24 at approximately 8:15 AM, an interview with MM E was conducted. MM E showed a sensor which had been unplugged from the soap dispenser to the wash compartment. MM E explained the vendor working on the machine had disconnected it because the machine was getting too much soap. Further he explained the vendor's repair was to disconnect the sensor so the soap would only be dispensed every third cycle. The sensor had been found on the floor, under the machine, following the over heating event. The sensor had obvious burn/fire residue on two nodes. It was reported the vendor was to be replacing the machine by the end of the day (5/20/24). The vendor was not observed on either 5/20/24 or 5/21/24, leaving the facility without a viable working dish machine.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 40383 Based on interview and record review the facility failed to include mandatory training outlining and informing their staff of the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program for 4 staff (identified as Staff N, P, R and Q) out of seven in-service training files reviewed for QAPI training. This deficient practice resulted in the potential for unmet resident care needs due to an ineffective performance improvement program. Findings include: All times are recorded in Eastern Daylight Time (EDT) unless otherwise noted. On 5/29/24, the employee records were reviewed to determine if individual staff had education on the facility's QAPI program. The computerized software education for QAPI was not found to be given to 4 of the 7 employees (identified as Staff N, P, R and Q) reviewed. During an interview on 5/29/24 at 10:50 AM, Housekeeping staff MM was asked about education on the facility's QAPI program. Staff MM stated, They give us papers to read and sign. We do not get to keep a copy of the papers. There are no classes when they give us papers to sign. Staff MM could not remember any training on quality improvement. When asked about quality projects and goals the facility was working on, Staff MM said, I do not know what the facility is working on. During an interview on 5/29/24 at 10:55 AM, Certified Nursing Assistant (CNA) LL stated, We have quality education on (the computerized software) but CNA LL did not know the quality projects and goals the facility was working on. During an interview on 5/29/24 at 10:59 AM, Registered Nurse (RN) JJ stated, We get quality improvement education on PIPs (Project Improvement Plans), so I know what they are, but I do not know projects the facility is working on. RN JJ said, I know they have quality meetings. RN JJ did not know what they talked about or worked on in the meetings. RN JJ said, I have never been asked to attend. I was probably working. During an interview on 5/29/24 at 11:03 AM, CNA KK stated, I have not had (the computerized software) training but I know it is on (the computer). CNA KK did not know the quality improvement goals or quality projects the facility was working on. During an interview on 5/29/24 at 12:32 PM, the NHA acknowledged the computerized software education logs revealed 4 of the 7 employees records indicated they had not been trained in the QAPI program and interviews with staff revealed 4 of 4 staff interviewed were unfamiliar with the building's quality goals and quality improvement projects in the QAPI program. The facility provided the policy Quality Assessment and Process Improvement which was dated as issued 10/15/2018 with no recent review dates and unsigned blank areas indicating no approval by Administration or Medical Director. This policy read in part: .Communications: The staff on all levels should be aware of the facility's progress. Some ideas for facility to use for staff communication: (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Communication board in staff areas to inform of: Upcoming projects and the status of current projects Facility progress in regards to all different departments (falls, skin, dietary, satisfaction) o Staff meetings to inform staff of current problem areas and obtain ideas from staff o QAPI Newsletter o Drop box for improvement ideas