STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 1 (Resident #8) of 20 residents reviewed for accommodation of needs, resulting in the inability to call for staff assistance and the potential for unmet care needs. Findings include: Review of an Admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unsteadiness on feet. Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 8/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #8 was moderately cognitively impaired. Review of Resident #8's Care Plan revealed, Category: ADLs (Activities of daily living) Functional Status/Rehabilitation Potential. Alteration in ADLs - self care deficit r/t (related to) H/O (history of) CVA (cerebrovascular accident-a stroke) with L sided weakness .Problem start date:3/27/17 .Approach: .Call light to be within reach . During an observation on 9/25/24 at 10:04 AM, Resident #8 was lying in his bed. His call light was noted to be on the floor and out of reach. During an observation and interview on 9/25/24 at 12:27 PM, Resident #8 was sitting up in his bed. Resident #8 reported that he used his call light to ask for help when he needed it, but sometimes he could not find his call light. During an observation and interview on 9/26/24 at 9:05 AM, Resident #8 was lying in bed. Resident #8's call light was noted to be on the top left side of his bed. It was noted that Resident #8 was not able to reach his call light when asked if he was able to use his call light. During an observation on 9/27/24 at 10:02 AM, Resident #8 was lying in bed. Resident #8's call light was noted to be under his bed and out of Resident #8's reach. During an interview on 9/27/24 at 1:34 PM, Certified Nursing Assistant (CNA) Y reported that Resident #8 did use his call light to ask for assistance from staff when needed.

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41982 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for 1 (Resident #42) of 5 residents reviewed for medications, resulting in an incomplete reflection of the resident's care and monitoring needs for anticoagulant therapy. Findings include: Resident #42 Review of an Admission Record revealed Resident #42 was a female, with pertinent diagnoses which included: congestive heart failure and hypertension (high blood pressure). Review of a Physician's Order revealed Resident #42 was prescribed an anticoagulant, Eliquis (apixaban) tablet; 2.5 mg (milligrams); amt (amount): 2.5 mg; oral Special Instructions: DX (diagnosis): HX (history) DVT (deep vein thrombosis - a blood clot) Twice A Day . with a start date of 7/9/24. Review of Resident #42's current Care Plan revealed no care planned problem, goal, or approach related to Resident #42's anticoagulant therapy. In an interview and record review on 9/26/24 at 2:27 PM, MDS Coordinator (MDSC) EE reported that he was responsible for creating care plans for high-risk medications, including anticoagulants. MDSC EE reported it was important to care plan anticoagulants because of their potential side effects, including heavy bruising. MDSC EE reviewed Resident #42's current Care Plan with this surveyor and reported there was no care plan in place for her Eliquis but that there should have been. In an interview on 10/1/24 at 9:43 AM, Director of Nursing (DON) B reported care plans should be created for high-risk medications, including anticoagulants, because there were potential side effects to the residents on those medications that staff needed to be aware of and to watch for.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to implement care plan interventions to prevent worsening of contractures for 1 (Resident #1) of 2 residents reviewed for range of motion resulting in the potential for worsening of contractures (a condition of shortening and hardening of muscles, tendons, or other tissue often leading to deformity and rigidity of joints). Findings include: Review of an Admission Record revealed Resident #1 was originally admitted to the facility on [DATE] with pertinent diagnoses which included contracture of muscles. Review of Resident #1's Occupational Therapy Discharge Summary dated 5/3/24 revealed, .Discharge Recommendations: . Right hand T bar splint (a device used to treat contractures) on with am care and off at lunch or as tolerated, LUE (left upper extremity)hand roll/carrot or gauzed during as tolerated and LUE elbow position device on with AM care and off at lunch or as tolerated . Review of Resident #1's Care Plan revealed, Category: ADLs (Activities of daily living) Functional Status/Rehabilitation Potential. Alteration in ADLs - self care deficit r/t (related to) quadriplegia . Problem start date: 5/1/2019. Approach: after PROM (passive range of motion) to BUE (bilateral upper extremities) with AM care place dark blue hand roll with Velcro in right hand, and gauze in L hand, remove at lunch or as tolerated by patient. Approach date: 9/30/24 . During an observation on 9/25/24 at 11:46 AM, Resident #1 was sitting in his wheelchair in the dining room. It was noted that Resident #1 was not wearing any splints on his right hand or left hand and elbow. During an observation on 9/27/24 at 10:01 AM, Resident #1 was sitting in his wheelchair in the dining room. It was noted that Resident #1 was not wearing any splints on his right hand or left hand and elbow. During an observation on 9/27/24 at 10:44 AM, Resident #1 was lying in his bed resting. It was noted that Resident #1 was not wearing any splints on his right hand or left hand and elbow. During an interview on 9/27/24 at 10:17 AM, Physical Therapy Assistant (PTA) II reported that Resident #1 discharged from occupational therapy on 5/3/24. PTA II confirmed that at the time of Resident #1's discharge, therapy recommendation was for Resident #1 to wear a right hand t bar splint and LUE roll, hand, carrot or gauze as Resident #1 could tolerate. PTA II reported that the expectation was that the facility's Certified Nursing Assistants (CNA's) would place the splints on Resident #1 in the morning with his morning care. During an interview on 9/27/24 at 1:34 PM, CNA Y reported that Resident #1 did not typically refuse cares or wearing his assistive devices. CNA Y reported that she did think that Resident #1 was supposed to wear splints during the day. CNA Y did not know why Resident #1 was not wearing his splints on 9/27/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 This citation pertains to intakes MI00145027 and MI00145248. Based on observation, interview, and record review, the facility failed to ensure a safe environment and implement safety interventions for 1 (R15) of 2 residents reviewed for accidents and hazards, resulting in a fall with facial bruising and laceration that required sutures, and the increased potential for further falls with injuries. Findings include: According to the Minimum Data Set (MDS) dated ,d+[DATE], R15 scored 5/15 (cognitively impaired) on her BIMS (Brief Interview Mental Status) with no impairments to either her arms or legs, the resident was able to independently wheel 150 feet in a corridor or similar space once seated in a wheelchair. Her diagnoses included dementia. Review of R15's Safety Event-Fall Event, event date 6/5/24, indicated at 6:10 PM the resident was discovered after wheeling down by the chapel (sic) and fell out of wheelchair. The resident had been self-ambulating in her wheelchair near the chapel prior to the fall. There were no witnesses to the fall. After the fall the resident exhibited/complained of pain to her head. Assessment of pain revealed the resident had sustained a head injury with a laceration/open area to her forehead. R15 was unable to complete ROM (range-of-motion) and experienced dizziness/lightheadedness/ headache with confusion. Possible contributing factors included balance problem and cognitive impairment. Immediate intervention included sending the resident to the ER (emergency room) for further evaluation and treatment. The intervention that was to be put in place to prevent further falls was to place yellow caution floor signs in the area of fall. The Post Fall Risk Assessment identified R15 had a history of two or more falls in the past year with injury. Medications the resident was taking at the time of fall included psychoactive, sedative, and anti-hypertensive. The resident had impaired vision and wore glasses. A fall risk evaluation after the fall gave R15 a score of 19. 0 indicating she was at a high-risk level of fall probability. During an interview on 9/25/24 at 11:44 AM, Family Member (FM) FF stated, Family was told she (R15) had a fall and was sent to the hospital. Family was told she fell out of her wheelchair down by the chapel. Why was she down there by herself? How was it the person in charge of her did not know where she was? Review of R15's Care Plan, date 6/12/23, identified the resident at risk for falls and subsequent injury related to dementia, altered mental status, history of falls, limited mobility, and weakness. The goal was to prevent or reduce the occurrence of falls and subsequent injury related to falls. The approach/interventions to meet this goal included: -6/5/24 Yellow cautions floor signs by Chapel -5/3/24 Keeping resident in high traffic areas when awake (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/11/24 Husband was encouraged to let staff know when he was leaving, and staff will provide closer observation -6/20/23 Staff to assist resident to nurse's station during periods of increased confusion and when experiencing acute anxiety -5/15/24 Resident not to be left unattended in wheelchair in dining room Observed on 9/25/24 at 9:40 AM, R15 was in the dining room seated alone at a table in her wheelchair. No staff were visible. Observed on 9/25/24 at 9:45 AM, area leading to the Chapel at the intersection of the South and [NAME] halls. At the intersection was the therapy room. Just past the therapy room was a ramp descending down to the Chapel. No yellow caution signs or strips were in place to warn of the descent. During an observation and interview on 9/26/24 at 8:50 AM, R15 was in the dining room seated alone at a table in a wheelchair. Four other residents were in the dining area finishing up their breakfast. No staff were present. The wheelchair's right foot pedal was folded down and her foot on it. The left foot pedal was extended in front of her with it folded up. Resident had slight yellowing bruises to her face on her cheeks and under her eyes. A light red scar was on her forehead. During an observation and interview on 9/26/24 at 9:10 AM Certified Nursing Assistant (CNA) DD stated, I take care of (R15) quite a bit. I was off when she fell . She will move herself around the facility in her wheelchair. Sometimes when her husband comes in, he will transfer her into her bed without assistance. Staff have to keep her in the common area to watch her because she will wander away and will try to transfer without help. Observed R15 sitting in wheelchair by nursing station. One foot pedal was turned up and the other was folded down. The resident tried to shuffle her feet on the floor and her legs became tangled in the foot pedals. During an interview and record review on 9/26/24 at 12:36 PM Director of Nursing (DON) B stated while reviewing R15's medical record, (R15) has had a few falls since she was admitted . She tries to self-ambulate in her wheelchair and will go all over in the halls, so staff try to keep her up by the East nursing station. (R15's) chart indicates she had falls on April 16 (2024), May 3 (2024) when she got a laceration over her left eye, May 15 (2024), and June 5 (2024) when she tipped over in her wheelchair by the Chapel and got stitches in her forehead. Her care plan for Falls state the facility was to apply yellow strips to the floor at the start of the ramp to the chapel as an intervention after this fall. The strips were never put down. I'm going to remove this from (R15's) care plan. It was noted R15's Care Plan was revised on 9/26/24 at 2:37 PM by DON B. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 3:25 PM Registered Nurse (RN) O stated, (R15) had a bad fall on 6/5/24. I was not her nurse. That nurse no longer works at facility. (R15) resides on the East side of the building. She is always self-ambulating in her wheelchair all over the facility. On that day, 6/5/24, I saw (R15) wheeling down by my station on the [NAME] side of the building. Then go down the hall towards therapy where the chapel on the South Hall. The chapel has a ramp that goes down to it and is not very safe. Can you imagine a resident in a wheelchair going down that ramp? The next thing I heard was (LPN O) yelling for help because she had found (R15) had fallen. When I got there (R15) was at the bottom of the ramp into the chapel. She and her wheelchair had tipped over onto the left side. There was blood all over the place and she had a laceration on her forehead. I called 9-1-1 and (R15) was sent out to the ER. (R15) still goes around the facility and she is fast. If she can't wheel herself around using her feet, she uses the handrails. That ramp is dangerous. There were never any yellow strips put on the floor. Review of R15's Progress Note dated 6/5/24 6:19 PM, revealed, Resident was observed on the floor down by the chapel by the South Hall nurse .Resident was bleeding profusely from forehead .Sent resident out to hospital for further evaluation. Review of R15's Hospital After Visit Summary, dated 6/5/24, indicated the resident was seen on 6/5/24 for a fall that resulted in an injury to the resident's head including a facial laceration and traumatic hematoma of the forehead. The resident received laceration repair consisting of sutures (stitches). Review of R15's Progress Note dated 6/6/24 1:47 AM, revealed, Resident arrived back to the facility from (name of area hospital ER) .stated she was having pain in her head . Review of R15's Progress Note dated 6/7/24 4:48 AM, revealed, .continues to have swelling around bilateral eye lids with purple and black bruising. Resident has sutures to forehead . Attempt to contact Licensed Practical Nurse (LPN) V on 9/26/24 at 3:40 PM leaving a message to return call. No contact was made by survey exit 10/1/24 at 5:30 PM.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to attempt a required Gradual Dose Reduction (GDR) of antidepressant and antipsychotic medications for 1 (Resident #22) of 5 residents reviewed for unnecessary medications, resulting in the potential that the resident was receiving the medication at an unnecessary dose or for an unnecessary length of time. Findings include: Resident #22 Review of an Admission Record revealed Resident #22 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified mood affective disorder. Review of Resident #22's Physician's Orders revealed, Olanzapine (Antipsychotic medication). 2.5 mg (milligrams) twice a day. Start date 7/16/24 . Olanzapine. 5 mg at bedtime. Start date: 7/16/24 Sertaline (Antidepressant medication). 25 mg daily. Start date: 7/16/24 . Review of Resident #22's Care Plan revealed, (Resident #22) has a DX (diagnosis) of psychosis, delusional disorder, dementia with behaviors and experiences resistance with care, inappropriate comments towards staff, and receives antipsychotic medication. Resident #22's mood and behaviors do vary and fluctuate . Approach: . Dose reduction as ordered. Approach date: 9/14/22 . Review of Resident #22's Psychoactive medication quarterly evaluation dated 9/18/24 and completed by Social Worker (SW) E revealed, .Description: Sertaline .Evaluation: Appears controlled .Last dosage reduction: no date noted . Review of Resident #22's Psychoactive medication quarterly evaluation dated 9/18/24 and completed by Social Worker (SW) E revealed, .Description: Olanzapine .Evaluation: Appears controlled .Last dosage reduction: no date noted . Review of Resident #22's (Local mental health provider) note dated 10/19/23 revealed, . History of present illness .Since the last encounter, (Resident #22) is now taking Nuplazid (medication used to treat hallucinations and delusions associated with Parkinson's disease), Zyprexa (antipsychotic) was successfully tapered and discontinued. There has been little improvement with this change. Staff members note that this is likely part of the course of his chronic conditions. We discussed the possibility for (Resident #22) to return on an as needed basis to minimize the amount of doctor's visits the patient has to attend. This is reasonable at this time . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's (Local mental health provider) note dated 9/11/24 revealed, Found (Resident #22) at the nurses station and we went to his room to talk. Explained that I am leaving the agency at the end of September and that we are getting ready to discharge him from our services. I said that the nursing home's psychiatric provider would take care of seeing him to make sure he's on the right psychotropic medications, the right doses, and that he is doing ok on his meds and not having any problems . It was noted that this local mental health provider visit was not an assessment; rather, a visit to inform of discharge from service. Review of Resident #22's Electronic Health Record (EHR) revealed no documentation for any attempts for GDR's since October 2023, or any documentation of risks verses benefits to justify why a gradual dose reduction attempt was not indicated for Resident #22. During an interview on 9/27/24 at 1:55 PM, Director of Nursing (DON) B reported that she was unable to report the last time that Resident #22 had a GDR attempt. DON B was unable to report if there was any clinical indication to justify why the facility had not attempted a GDR of Resident #22's psychotropic medications. DON B did not know if Resident #22 was followed regularly by local mental health provider, or if the facility's physician was collaborating with the local mental health provider for Resident #22's psychotropic medication regimen. During an interview on 9/27/24 at 1:44 PM, SW E reported that Resident #22 was being followed by a (local mental health provider) and was last seen by the (local mental health provider) in October 2023. SW E did not know why Resident #22 had not been assessed by the (local mental health provider) in almost a year, and could not report who was responsible for scheduling follow up visits for Resident #22. SW E reported that the facility had not attempted any GDR's of Resident #22's psychotropic medications because he was followed by the (local mental health provider) and the facility was relying on the (local mental health) provider to determine Resident #22's need for GDR attempts. SW E reported that she was only responsible for competing the psychoactive medication quarterly evaluations for Resident #22, and she did not have any other information regarding Resident #22's psychoactive medications. SW E was unable to report how the facility was collaborating with the (local mental health provider) to manage Resident #22's psychoactive medications. The facility was not able to provide any further documentation regarding any GDR or clinical justification for why a GDR was not appropriate for Resident #22 prior to survey exit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to ensure residents remained free from significant medication errors, when professional standards of medication administration were not followed for 1 (Resident #16) of 1 resident reviewed for insulin (works to lower blood sugar levels in your body) administration, resulting in the potential for serious adverse effects from an excessive dose of insulin. Findings include: Resident #16 Review of an Admission Record revealed Resident #16 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes (when the body cannot properly control blood sugar levels). Review of a Minimum Data Set (MDS) assessment for Resident #16, with a reference date of 8/9/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #16 was cognitively intact. In an interview on 09/26/24 at 09:18 AM, Resident #16 reported that she had received the incorrect dose of insulin about 1 week prior. Resident #16 reported that shortly following administration of her morning insulin, she began not feeling well, could not keep her eyes open, felt very fatigued and stated, .the physical therapist notified a nurse for me . Review of Resident #16 Progress Note dated 09/18/2024 at 11:11 AM revealed, Medication error done this morning with insulin. Resident was given 32U (units) of fast acting insulin instead of 20U Long acting (meaning that it starts to work after 30 minutes to 4 hours, and last for 16-24 hours to manage the body's general needs) and 2U Lispro (short-acting: rapidly reduces blood sugar levels at mealtimes). PT (physical therapist) came and got this nurse stating that the resident isn't acting right. Took manual BP (blood pressure) and it was 100/50 with blood sugar at 54. Gave 15g (grams) of carbs (carbohydrates) with 8 oz (ounce) of milk. Rechecked resident blood sugar and it was 83 and resident is stable. Documented by Registered Nurse (RN) O. The details in the note were not consistent with actual physician orders. Review of Resident #16's Physician Orders indicated the following orders for insulin were in place on 9/18/24: Insulin Aspart (short acting), to be administered before meals, and per sliding scale when blood sugar was 150-199, 2 units should be administered. Also Insulin Degludec (long-acting), 30 units to be administered twice daily. Review of Resident #16's Blood Sugar Results dated 9/18/24 at 8:00 AM revealed 186 and then at 10:45 AM revealed, 54. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/27/24 at 03:45 PM, RN CC reported that she was working on her own on 9/18/24, when she accidentally administered the wrong type and amount of insulin to Resident #16. RN CC reported that she was supposed to administer 2 units of the short acting and 30 units of the long acting, but instead administered 32 units of short acting. RN CC reported that she prepared 2 units of the short acting insulin first, and then instead of grabbing the long acting insulin pen, she used to short acting insulin vial, and prepared another 30 units of insulin. RN CC reported that she was nervous and in a rush due to being new to skilled nursing, and did not verify that she had the correct type of insulin when she prepared the doses. In an interview on 09/27/24 at 09:18 AM, RN O reported that she was training RN CC on 9/18/24, when RN CC administered the incorrect dose of insulin to Resident#16. RN O reported that RN CC was new, had completed her orientation period, but had requested additional training days. RN O reported that normally a new nurse would not be allowed to administer medications on their own, but since RN CC had completed the required 3 days of orientation, RN O thought that it would be ok to allow RN CC to work on her own. RN O reported that a therapist had notified her of Resident #16's change in condition; Resident #16 was zonked out. RN O reported that she obtained Resident #16's vital signs and discovered that her blood sugar was only 54. RN O reported that she gave Resident #16 chocolate milk, and pudding, but that RN O had to speak very loudly and keep encouraging Resident #16 to drink. RN O reported that Resident #16 came back around within a couple minutes, but that it took 2-3 hours for her to fully return to her normal self. RN O reported that Resident #16 missed her dialysis appointment that day, as a result of the medication error that caused her change in condition. In an interview on 09/27/24 at 02:07 PM, Director of Therapy (DOT) II reported that she was with Resident #16 on 9/18/24 following the administration of incorrect insulin. DOT II reported that Resident #16 was standing up, when she began complaining of shortness of breath, being shaky, not feeling well, and then she became verbally non-responsive. DOT II reported that she notified the nurse right away. In an interview on 09/27/24 at 02:12 PM, Director of Nursing (DON) B reported that she investigated the medication error that occurred on 9/18/24 for Resident #16. DON B reported that RN CC was a new nurse with the facility, was still in her orientation period, and was not working on her own yet. DON B reported that RN O was training RN CC, but DON B was not sure if RN O had been with the new nurse when the medication error occurred. DON B reported that RN CC administered that wrong type of insulin, and the wrong dose of insulin. DON B reported that she educated RN CC about the rights of medication administration.

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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. 38905 Based on observation and interview the facility failed to employ either a full time Registered Dietitian or Certified Dietary Manager to provide oversight of kitchen and clinical nutritional services. This deficient practice has the increased potential to result in food service sanitation failures, food borne illness, or inadequate assessment of high-risk residents among all residents. Findings include: During a tour of the kitchen, at 8:35 AM on 9/26/24, an interview with Dietary Supervisor (DS) S, found that the facility does not have a full-time dietitian, but a dietitian comes in a couple times a week. When asked if she was a Certified Dietary Manager (CDM), DS S stated that she is not yet but is taking the classes. When asked how long she has been the Dietary Manager, DS S stated about two years. When asked how the CDM class was going, DS S stated it's been hard to fit it in sometimes, but she is getting an extension so she can complete it.

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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. 38384 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 all residents. Findings include: During a tour of the kitchen, starting at 10:00 AM on 9/25/24, Dietary Aide (DA) R stated, The manager is to rotate food supplies. Staff are to date food when they are opened. Opened food has a three-day out expiration date. Staffing is short in the kitchen and it is hard to get things done when there is only two staff in here today. Observation of the kitchen included: Dishwasher Area - a bucket of powdered detergent was sitting next to the dishwasher under the shelf. Powdered detergent was spilled on the shelf with discoloration from dripping water and on the floor. Dish Area -three-compartment sink to be leaking behind it with a container underneath the sink to catch leaks. A bucket of liquid detergent on the floor next to the sinks was covered with dirt and debris with a blue substance accumulated on the floor next to it. A bed blanket was also on the floor next to the detergent bucket. The blanket was saturated with liquids, dirt, and debris. Kitchen Prep Area - two clean utensil drawers that contained spoons and mechanical scoops to have an accumulation of crumbs and debris in the drawer. The spatulas were cracked with broken edges. Equipment -metal sauce and sheet pans to have excess build up on the inside sides and corners. - shelving units found to have dried food debris, waded paper, plastic, and bag ties on the shelves. - crockpot, disposable pan (with a straw paper, and broken plastic drink cup lids) were covered in dust and debris. An undated jar of peanut butter, loose and wadded up gloves, pieces of aluminum foil and paper. -food prep counter found to have two- blue plastic containers with adaptive utensils and sippy cups. In the bottom of the container was dust and debris. On the utensils were dried substances resembling food. Cutting boards covered with dust and debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- third drawer of the table had a sticky substance in the bottom of the drawer. A hand mixer was covered in a sticky substance. An immersible blender had splattered dried substances on it. Scoops and cooking utensils had sticky and dried substances on them. -coffee area found the bottom shelf held four coffee dispensers and an empty plastic container. The container had a layer of dust, dirt, and debris. The shelf was covered in coffee grounds, dried coffee, and a layer of dust, dirt, and debris. Food/Non-food contact surfaces: -can opener found to have an increased amount of dirt and debris accumulation near the blade and rotating mechanism of the arm. -microwave had an increased amount of dried debris accumulated on the inside top portion. Ice Machine: -the ice scoop holder was located on the wall next to the ice machine with a table in front of it making it difficult to reach the scoop. The holder had 3-holes in the bottom that had an accumulation of a white substance. An ice scoop was lying on the table that had water accumulating in it. On the bottom shelf of the table were two boxes of plastic silverware in clear plastic bags. The bags were open to the air and splattered with dust and dried substances. Walk-in Cooler found inside the following without labeling/or any dating: -1/2 raw onion wrapped in clear wrap -2-partial sticks of butter in original wrapper, one on bottom shelf behind cardboard box -creamed corn in plastic container covered in clear wrap -three food undistinguishable food items wrapped in aluminum foil -plastic container of scrambled eggs -pastry dough in clear wrap -two 4 inch x 4 inch x 2 inch blocks of American cheese -plastic container of cheese sauce -cardboard box of wilted brown tipped celery -cardboard box of wilted brown edged romaine lettuce -uncovered box of eggs -empty cardboard egg container (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-green drink pitcher 1/4 full -small single carton of chocolate milk with manufacturer expiration date 9/8 with spots of green substance resembling mold. Dry Storage found the following without labeling/dating: -three clear plastic containers of dry cereal -quick-oats -one opened partially used bag of instant mashed potatoes -one opened partially used chicken gravy mix -one opened partially used biscuit gravy sauce mix -one opened partially used bag of lemonade mix. It was observed on all floor surfaces in kitchen area, including walk-in cooler and freezer were sticky, with dust and debris littering surface and along the edges. Plastic, paper, and bread ties were on the floor under shelving units and tables. 38905 During a tour of the kitchen, starting at 8:35 AM on 9/26/24, an interview with Dietary Supervisor (DS) S found that potentially hazardous foods get dated for a three-day discard. Observation of the walk-in cooler found an open container of sliced ham with no discard date. During a tour of the bunny patch resident refrigeration unit, at 10:06 AM on 9/26/24, an interview with DS S found that dietary, nursing, and activities takes care of this refrigeration unit for residents. When asked how long food product gets in the refrigeration unit, DS S stated three days. Observation inside of the unit found the following: A carton of milk with a best by date of 9/20/24, a container of whole intact grapes with fuzzy mold looking substance on the grapes, a container of unlabeled soup with a best by date of 9/12/24, an unlabeled container of Chinese takeout with a foul odor and many areas of mold looking growth covering the food product, and a container of puree mac and cheese with no date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . During a tour of the walk-in cooler, at 8:37 AM on 9/26/24, it was observed that a half pan chaffing dish, containing a half log (5lbs) of raw ground beef, was sitting on a box of romaine lettuce. When asked if this is where raw meat should be stored, and Regional Certified Dietary Manager (CDM) LL stated no and moved the meat to a lower shelf. During a tour of the dry storage room, at 9:41 AM on 9/26/24, it was observed that a large open bag of rice was found on the dry storage room floor open and exposed with no covering. Further observation found a box of linguini noodles open and exposed while on a storage self. An interview with Regional CDM LL found that those items should be stored in closed containers. According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,(b) Cooked READY-TO-EAT FOOD . (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the FOOD in packages, covered containers, or wrappings . During a tour of the kitchen, at 8:56 AM on 9/26/24, observation of the can opener found an increased amount of dirt and debris accumulation near the blade and rotating mechanism for the arm. An interview with DS M found that the can opener had not been used today and the dietitian has stated that a new one is needed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the clean utensil drawers, at 8:58 AM on 9/26/24, it was observed that the two drawers containing spoons and mechanical scoops were found with an accumulation of crumbs and debris from the inside surface of the drawers being chipped and scraped over time. Observation of the inside top clean utensil drawer found heavy accumulation of metal filings on the inside back where debris accumulates. During a tour of the kitchen, at 9:00 AM on 9/26/24, an increased amount of dried debris accumulated on the inside top portion of the microwave. During a tour of the ice machine area, at 9:01 AM on 9/26/24, it was observed that the ice scoop holder had an accumulation of black spotted debris on the inside bottom of the holder. When asked if the ice scoop holder gets cleaned, DS S stated it's on a cleaning list. During a tour of the kitchen, at 9:10 AM on 9/26/24, it was observed that an added amount of accumulation of dust debris was evident on the ceiling above the back preparation table near and around the lights and exhaust vent in this area. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . During a tour of the dish machine area, at 9:23 AM on 9/26/24, it was observed that the overhead spray to the left of the dish machine was found hanging below the overflow rim of the sink, leaving a cross connection that could contaminate the potable water supply. During a tour of the dish area, at 9:25 AM on 9/26/24, observation of the three-compartment sink found it leaking on the back side with a rubber container underneath the sink to catch any leaks. Observation of the overflow drain found that it discharges water onto the floor behind the sink. According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. During a tour of the Bunny Patch, starting at 10:06 AM on 9/26/24, it was observed that the ambient temperature of the refrigeration unit was found to be 54F according to the ambient air thermometer located in the unit. When asked if the unit had been having troubles, DS S was unsure. At this time a temperature of a food product of puree mac and cheese was taken with a rapid read digital thermometer and found to be 53F. No log was observed on or around the unit to show staff were regularly checking the temperature of the unit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 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 57C (135F) 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 54C (130F) or above; or (2) At 5C (41F) or less. During a tour of the kitchen, at 9:33 AM on 9/26/24, it was observed that some sauce and sheet pans were found with excess carbon build up on the inside sides and corners of surfaces. When asked if staff use this equipment, DS S stated that sometimes, but most of it doesn't get used, I should go through them. According to the 2017 FD Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2 . Observation of the kitchen preparation table with the toaster, at 9:50 AM on 9/26/24, found a couple containers of PDI hand sanitizer wipes. An interview with Dietary [NAME] R found that she uses the wipes sometimes to clean the temperature thing. The wipes label states they should be used on your hands and contain added ingredients for moisturizing, such as aloe, which is not food grade. According to the 2017 FDA Food Code section 3-302.14 Protection from Unapproved Additives. (A) FOOD shall be protected from contamination that may result from the addition of, as specified in S 3-202.12: (1) Unsafe or unAPPROVED FOOD or COLOR ADDITIVES .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38905 DPS A Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). Findings include: During an interview with Maintenance Director M regarding the facilities Water Management Plan, at 3:40 PM on 9/26/24, it was found that the facility does routine flushing of domestic fixtures to help remove stagnant water from their system. When asked what other control measures are put in place to reduce the risk of OPPP from growing and spreading, MD M was unsure. When asked if the facility does any testing of the water, MD M stated that he has been waiting on a tester to do that. When asked if the water line in the family room, behind where the old refrigeration unit was, is being flushed, MD M stated it was not one that he would flush. A review of the Water Management Plan binder found an annual review from August 2023. When asked if he has gone over the WMP with the administrator, MD M stated not yet. During a review of the facilities Water Pathogen Risk Reduction document, not dated, found that, 1. Each Atrium facility shall develop, document and implement a comprehensive Legionella water management plan (LWMP or plan) for all building water systems that may be at risk as a source of Legionella. The plan is a continuous process and shall include the approach outlined in the procedure section of this policy. Further review found that 5. Risk mitigation efforts will be followed based on facility risk classification. Water Pathogen Risk Reduction. 6. Routine reassessment annually and when there are changes that could impact risk. 7. Document the plan accordingly on enclosed logs & assessment form. 47659 DPS B: Based on observation, interview, and record review, the facility failed to operationalize an effective infection control program resulting in the potential for the development and transmission of communicable diseases and infections. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/26/24 at 12:53 PM, Infection Preventionist (IP) C reported that she had been overseeing the facility's infection control program since March 2024. IP C' reported that she was responsible for monitoring all resident vaccines upon admission and annually, but confirmed that she had missed ensuring some residents had received vaccines, and did not have a thorough process for tracking residents that were due for vaccines and obtaining consents for vaccines. IP C reported that there had been several staff members covering the IP position prior to March, and she was still trying to play catch up with resident vaccines. IP C was unable to report how the facility was ensuring that staff were trained on cleaning and disinfecting reusable medical equipment and environmental cleaning. IP C provided a meeting sign in sheet from March 2024 which noted the topic of Antibiotics was discussed, but IP C was unable to report what was covered on the topic and who presented the topic. IP C also had a copy of a handout on Influenzadated January 2024, but she was not able to report what kind of education was provided to staff on this topic, or which staff received the education. IP C was not able to provide any examples of infection control education that she had provided to staff. IP C provided an Monitoring Compliance with Infection Control Checklist form for September 2024 which listed several areas to audit such as Is equipment clean ? (i.e., bedpans, urinals, ect.)? , Are personal belongings being marked, stored?, Is resident clean, dry, personal care being done? . The check lists that were completed did not note which areas of the facility were audited. IP C could not explain how she was keeping track of what areas she had and had and/or not audited. IP C did not have any other examples of infection control audits that she had completed. IP C was not able to report how often the facility was reviewing and updating the infection control policies and procedures, or how the facility was incorporating the facility assessment into the infection control program. IP C was not able to report how the facility tracked employee illness. IP C reported that she was supposed to be informed when staff members were sick, but she could not verify that the facility was following that process. IP C was not able to report how the facility's infection surveillance program included early detection of potential infectious residents that may require laboratory testing and/or implementation of transmission based precautions. IP C reported that she did not keep a list of residents that could have potential infections or were experiencing potential infection symptoms. IP C reported that she only tracked and entered residents for infections if they had been prescribed an antibiotic. IP C was not able to report how she monitored the residents with infections, and reported that her process varied, but she often relied on nursing progress notes, and that she tried to review them daily, but ultimately the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were reviewing the notes more often than IP C. IP C reported that she had been trained by the facility's corporate staff, but was not able to provide details on what kind of training she had been given for the infection control monitoring and surveillance process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview on 10/01/24 at 11:53 AM, Infection Preventionist (IP) C reviewed her infection control log for September 2024 with surveyor. The log contained a facility map with rooms that were colored if the resident in that room had been prescribed an antibiotic. IP C was not able to show any further line listings to provide information on the resident's onset of symptoms, diagnosis date, antibiotics used, or any kind of infection control monitoring. IP C reported that she was not tracking or following up on infection information because nursing staff were completing infection charting on residents with diagnosed infections. IP C reported that nursing staff were responsible for infection monitoring. The September log also contained printed copies of lab results for residents that were diagnosed with infections in September and a printed reported from the facility's corporate infection tracking system. IP C confirmed that the only residents on the report from the facility's corporate infection tracking system were residents that had been prescribed an antibiotic. IP C also provided a staff education sign in sheet for September 2024 for Urinary Tract Infections. IP C reported that the education provided was her talking to staff about the topic. IP C confirmed that the only staff members that were provided that education were the staff members working the day of the education and she had not ensured that all nursing staff were provided the education. IP C reported that because she was new at the IP position, she was still being assisted by DON B and that DON B would be able to provide more insight into the infection control program than IP C. IP C confirmed that the documents reviewed with surveyor were all the documents she had for her infection control program. During an interview on 09/27/24 at 1:55 PM, DON B reported that she was not overseeing or monitoring the facility's infection control program, and that IP C was responsible for and completing all of the infection control program monitoring and tasks.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to 1.) Implement and operationalize an antibiotic stewardship program and 2.) failed to monitor to ensure appropriate use of an antibiotic for 1 (Resident # 368) of 5 residents reviewed for antibiotic use, resulting in the potential for inappropriate antibiotic utilization and antibiotic resistance. Findings include: Resident #368 Review of an Admission Record revealed Resident #368 was originally admitted to the facility on [DATE] with pertinent diagnoses which included cellulitis. During an interview on 10/01/24 at 11:53 AM, Infection Preventionist (IP) C reported that the facility utilized Mcgeer's criteria when residents were prescribed an antibiotic. IP C reported that any time a resident was prescribed an antibiotic, she was responsible for reviewing the resident's record to ensure that Mcgeer's criteria was used. IP C confirmed that Resident #368 had been on an antibiotic in September 2024. IP C reviewed Resident #368's electronic health record (EHR) with surveyor and reported that she was not able to find that Resident #368's antibiotic use had been assessed, and that she had missed ensuring that Mcgeer's criteria had been used for Resident #368. IP C was not able to provide a list of residents that were on antibiotics, or documentation of the indication, dosage, or duration of use for the antibiotic. IP C reported that she typically did not follow up with reviewing the outcome of a resident that was prescribed an antibiotic, because nursing staff would document on the resident. IP C was not able to report the facility's process for providing feedback on reports of antibiotic use, antibiotic resistance patterns based on laboratory data, or prescribing practices for the prescribing practitioner. IP C reported that because she was new at the IP position, she was still being assisted by DON B . IP C confirmed that the documents reviewed with surveyor were all the documents she had for the facility's antibiotic stewardship program. During an interview on 09/27/24 at 1:55 PM, DON B reported that she was not overseeing or monitoring the facility's antibiotic stewardship, and that IP C was responsible for and completing all of the antibiotic stewardship monitoring and tasks.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure residents were screened for eligibility to receive pneumococcal vaccinations and receive vaccination if eligible for 1 (Resident #22) of 5 residents reviewed for vaccinations, resulting in the potential of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. Findings include: Resident #22 Review of an Admission Record revealed Resident #22 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe). Review of Resident #22's Consent for vaccines form dated 10/22/23 indicated that Resident #22's guardian had received and read the Pneumococcal vaccine information, risks, and benefits, and would like to receive the Pneumococcal vaccine as recommended. Resident #22's guardian wrote on the consent As long as it is outside if three years since last . This form was signed by Resident #22's guardian on 10/22/23. Review of Resident #22's MCIR (Michigan Care Improvement Registry) indicated that Resident #22 had received a Prevnar 13 Pneumococcal vaccine on 9/7/2017 was due for the next recommended Pneumococcal vaccine on 9/7/22. During an interview on 9/26/24 at 12:53 PM, IP C confirmed that she was responsible for screening residents for vaccine eligibility,offering, and administering vaccines to all residents in the facility. IP C confirmed that Resident #22 was due for an updated Pneumococcal vaccine. IP C was not able to report why Resident #22 had not received a Pneumococcal vaccine. IP C reported that this must have just been missed. IP C reported that she had been trying to catch up the vaccines that were behind for residents since she took over the IP position in March 2024, and that the facility's vaccine program was behind due to staff turnover.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure Covid-19 immunizations were offered to 1 (Resident #51) out of 5 residents, reviewed for Covid-19 immunizations, resulting in the increased likelihood of infection and complications from Covid-19. Findings include: Resident #51 Review of an Admission Record revealed Resident #51 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe). Review of Resident #51's Electronic Health Record (EHR) did not indicate that Resident #51 had received any Covid-19 vaccinations. Review of Resident #51's Vaccine Consent Form dated 6/4/24 indicated that that Resident #51 had previously received Covid-19 vaccination, but did not indicate if he wanted additional doses. During an interview on 9/26/24 at 12:53 PM, Infection Preventionist (IP) C reported that she she was not able to locate any evidence that Resident #51 had been offered a Covid-19 vaccination. IP C reported that she was responsible for ensuring that Residents were screened for vaccine eligibility and offered the Covid-19 immunization. IP C reported that she had missed screening and offering a Covid-19 vaccine to Resident #51. IP C reported that she did not keep track of ensuring that all staff members were screened, educated, and offered the Covid-19 vaccine annually. IP C reported that she would post a sign for employees during the Covid-19 clinics, but she did not do anything further for staff members, and she was not sure if anyone else in the facility was tracking employee Covid-19 immunizations.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review the facility failed to maintain general cleanliness and repair of resident rooms, equipment, and aspects of the physical facilities for 5 of 38 residents (Resident #9, #50, #1, #8, and #10). Findings Include: During a tour of the facility, at 10:26 AM on 9/26/24, observation of resident room [ROOM NUMBER] found dust and debris under the bed and an accumulation of dirt debris around the perimeter and corners of the rooms vinyl coving. During a tour of the facility, at 1:54 PM on 9/26/24, it was observed that resident room [ROOM NUMBER] was found with increase staining and debris on the perimeter and corners of the room. Observation of shared resident bathroom found accumulations of dirt in the corners of the floor. Observation of the 200 hall Soiled Utility room, at 2:03 PM on 9/26/24, found numerous brown and stained ceiling tiles showing that possible roof leaks have been happening in this area. During a tour of resident room [ROOM NUMBER], at 2:08 PM on 9/26/24, it was observed that dirt and debris accumulation was evident on the perimeter of the room and underneath the register. Further observation found dirt and debris behind the recliner chair. During a tour with Supervisor of Housekeeping and Laundry (SHL) Q, at 2:16 PM on 9/26/24, observation of the 300 hall clean utility room found portions of the cabinets in disrepair with multiple chipped or missing portions of paint, making them no longer smooth and easily cleanable. These areas are used to store clean and sanitary supplies. During a tour of the 400 hall janitors closet, at 2:20 PM on 9/26/24 it was observed that the hot water valve would leak when turned on, further observation found a full spray bottle hanging on a rack, with no common name or label on the bottle. SHL Q stated it should be labeled. During a tour of the 400-hall clean utility, at 2:25 PM on 9/26/24, it was observed that some of the cabinets show heavy wear on surfaces no longer making them smooth and easily cleanable. Clean and sanitary supplies are stored on these shelves. During a tour of the central supply room, at 2:32 PM on 9/26/24, it was observed that a light shield is missing and has fallen down on one of the light fixtures. During a tour of the 200 Hall spa, at 2:53 PM on 9/26/24, it was observed that the padding to the shower bed was found to be cracked, ripped, and torn in numerous spots and the bed pad and is no longer smooth and easily cleanable in its current condition. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with NHA A, at 2:56 PM on 9/26/24, concerns regarding some of the older aspects of the home's environment were discussed. It was noted during the tour that some surfaces were found to have stained and discolored due to age and staff have a hard time making them look clean after being cleaned (such as vinyl coving in perimeter of some resident rooms). Concerns over the roof in parts of the 200 hall were discussed and found that the facility has received quotes for a roof replacement, but still need to fit it in a budget. During the tour in the 200 hall, it was noted that a large crack was present on the inside wall, outside of one of the resident suites. With SHL Q and NHA A, both were able to see directly into the room, with the door closed, due to cracking of the seams of the cinder block wall. NHA A and SHL Q were unaware of this crack prior. 41982 In an observation on 9/25/24 at 11:13 AM in room [ROOM NUMBER], noted several tiles on the floor that were worn down and appeared with gouge like marks in the floor. There was 1 ceiling tile above the resident bed that had a large dried brown stain covering approximately 1/3 of the tile. In an observation on 9/27/24 at 11:12 AM in room [ROOM NUMBER], noted 1 ceiling tile with a large dried brown stain covering approximately 1/3 of the tile above a resident bed. In an observation on 9/27/24 at 11:11 AM in room [ROOM NUMBER], noted several ceiling tiles with dried brown stains covering approximately 1/4 of each of the tiles. In an observation on 9/25/24 at 10:15 in room [ROOM NUMBER]B, noted there was no screen in the window. The window was open. There were 2 dead bugs in the interior of the window frame. In an observation on 9/25/24 at 2:05 PM in room [ROOM NUMBER]B, noted a damaged tile on the floor that had a round area (approximately the size of the palm of a hand) where the tile had broken away exposing what appeared to be concrete. In an interview on 9/27/24 at 12:10 PM, Maintenance Supervisor (MS) M reported the facility was planning to get the roof replaced and that ceiling tiles were on order. MS M reported the facility was hoping to get floors replaced by the first of next year. MS M reported nobody had reported that the screen in room [ROOM NUMBER]B was missing and that he would get it replaced as soon as possible. FANS: Resident #9 Review of an Admission Record revealed Resident #9 was a female, with pertinent diagnoses which included: chronic obstructive pulmonary disease (COPD). In an observation/interview on 9/25/24 at 9:58 AM, observed Resident #9 in her room, lying in her bed watching television. There was a portable oscillating fan that was located approximately 2 feet from the left side of Resident #9's bed near her left shoulder. The fan was blowing directly toward Resident #9's face. The blades and grates of the fan were caked with a moderate amount of dust. There was a box fan that was located on a shelf across the room, that was also blowing directly toward the resident. The blades and grates of this fan were also caked with a moderate amount of dust. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #50 Review of an Admission Record revealed Resident #50 was a female, with pertinent diagnoses which included: chronic obstructive pulmonary disease with acute exacerbation and emphysema. During an observation on 9/25/24 at 10:21 AM, observed Resident #50 in her room, lying in her bed watching television. There was a portable fan that was located approximately 3 feet from the right side of Resident #50's bed near her right hip. The fan was blowing directly toward Resident #50, who was wearing oxygen at the time. The blades and grates of the fan were visibly caked with a moderate amount of dust. There were several pea-sized balls of dust that were stuck to the fan grates, on the outer side of the grate away from the blades, with the blowing air directed over the dust balls toward Resident #50. In an interview on 9/26/24 at 1:23 PM, Housekeeper (Hsk) AA reported housekeepers were responsible for cleaning the fans in the resident rooms. Hsk AA reported fans were supposed to be cleaned once a month at the time of the monthly room deep clean, but if a fan became dusty in between that time, housekeepers should at least wipe them down. Hsk AA reported if there was a lot of dust on the blades and grates of the fan, the fan should be taken out of service and should be cleaned before continued use. In an interview on 9/26/24 at 1:26 PM, Hsk F reported housekeepers were responsible for cleaning the fans in the resident rooms every few weeks. Hsk F reported they didn't really go around and clean all the fans every month; rather, the fans were just cleaned when they were dirty or when the resident asked for their fan to be cleaned. In an interview on 9/26/24 at 1:36 PM, Assistant Director of Nursing (ADON) D reported Ambassador Rounds were completed by managers every week. ADON D explained that each week, managers visited their assigned residents and observed their rooms, completed the checklist, and reported any concerns to responsible departments. ADON D reported there was a variety of things managers checked on, and gave examples of ensuring proper call light placement, checking call light functionality, ensuring residents' needs were being met, etc. ADON D reported cleanliness of residents' fans was not on the list of things to check. In an observation/interview on 9/25/24 at 10:15 AM, Resident #56 was in her room seated in her wheelchair. The vinyl fabric on both wheelchair arm covers was significantly cracked and torn such that the foam underneath the vinyl was exposed. Resident #56 agreed that the arm covers of her wheelchair needed replaced. In an observation on 9/25/24 at 2:33 PM, Resident #32 was in his room seated in his wheelchair crocheting. The vinyl fabric on both wheelchair arm covers was significantly cracked and torn such that the foam underneath the vinyl was exposed. There was a significant amount of dirt and debris caked on the spokes of the wheelchair wheels as well as the wheelchair frame. In an interview on 9/26/24 at 1:33 PM, Certified Nurse Aide (CNA) T reported the third shift CNAs were responsible for cleaning resident wheelchairs and walkers. CNA T reported she was not sure if there was a cleaning schedule or not, but the expectation was if a CNA saw a dirty wheelchair or walker, they were to clean it. CNA T reported if something on a wheelchair needed repaired or replaced, the ADON was to be notified. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation/interview on 9/26/24 at 1:35 PM, ADON B reported third shift CNAs were responsible for cleaning the resident wheelchairs. ADON B reported that damaged wheelchair arm covers with foam exposed could not be cleaned properly and would need to be replaced. ADON B observed Resident #32's wheelchair with this surveyor and confirmed his wheelchair needed to be cleaned and the arm covers replaced. 47659 Resident #1 During an observation on 9/25/24 at 11:46 AM, Resident #1's wheelchair was noted to have a large tear on the right side with the material of the inside of the chair falling out of the tear. Resident #8 During an observation on 9/25/24 at 12:27 PM, Resident #8's bed was noted to have several pieces of food on his sheets. The right side of Resident #8's bed was noted to have several spots of a brown substance. Resident #8's beside tray table had several red stains and pieces of food on the table. Resident #8's floor was sticky beside and in front of his bed. It was noted that housekeeping had just left Resident #8's room and there was a wet floor sign on the outside of Resident #8's door, but the floor was not wet. During an observation on 9/26/24 at 9:05 AM, Resident #8's bedside tray table was noted to look the same as previous observations on 9/25/24. The right side of Resident #8's bed still had the several spots of a brown substance, and Resident #8's floor remained sticky with several pieces of food noted on the floor. During an observation on 9/27/24 at 1:27 PM, Resident #8's bed, bedside tray table, and room floor were noted to appear the same as previous observation. It was also noted that there were a few pieces of what looked like trash on Resident #8's floor next to and under his bed. Resident #10 Review of a Minimum Data Set (MDS) assessment for Resident #10, with a reference date of 8/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #10 was cognitively intact. During an observation and interview 9/25/24 at 9:30 AM, Resident #10 reported that she had concerns with the cleanliness of her bathroom. Resident #10 reported that she shared her bathroom with another resident, and she did not feel that the facility kept the bathroom clean enough to be a shared space. Resident #10 reported that she would often find feces on the toilet and floor, even after housekeeping cleaned the bathroom. Resident #10 reported that she had bought her own cleaning supplies and began to clean the bathroom herself. Resident #10 was not able to report how often the facility was cleaning her bathroom. Resident #10 reported that she had talked to facility staff about her concerns with the dirty bathroom before, but her concern about the bathroom remained an ongoing issue. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 9/25/24 at 10:10 AM, Resident #10's bathroom was observed with what looked like feces on the floor and wall near the toilet. There were several soiled briefs hanging on the towel rack and multiple bags of soiled clothing, towels, and wash cloths sitting on the bathroom floor under the sink. The mirror was covered with water marks and smears. The toilet appeared dirty and the inside of the toilet bowl had several stains. Resident #10 pointed out a spray bottle of Lysol that was sitting on the floor near the toilet and reported that was the spray she used to clean the toilet when there was feces on it. The bathroom floor was noted to be sticky, and the bathroom was noted to have a strong musty odor. During an observation and interview on 9/27/24 at 3:56 PM, Resident #10 reported that the facility's housekeeping staff had cleaned her restroom earlier that day. It was noted that the bathroom floor was sticky. The toilet had several brown spots which appeared to be feces on the side of the outside of the toilet and the inside of the bowl. The mirror was covered with water and smears. The smell of the bathroom was noted to have a strong musty order. During an interview on 9/27/24 at 1:34 PM, Certified Nursing Assistant (CNA) Y reported that she had heard Resident #10 voice concerns about the cleanliness of her bathroom before, but she did not know if the facility had initiated any interventions for Resident #10's concerns. CNA Y confirmed that Resident #10's bathroom was often dirty. 41027 During an observation on 09/25/24 at 10:05 AM in room [ROOM NUMBER] near bed 2, the floor was visibly dirty and had various paper and food debri (small peices of waste) around and under the bed and nightstand. The metal fan was powered on and had large clups of dust hanging from grates. In an observation and interview on 09/26/24 at 01:39 PM in room [ROOM NUMBER], Housekeeper (HSK) F reported that the floors in all resident rooms get cleaned every day, but that she did not mop in room [ROOM NUMBER] that day, because she was waiting until the resident was not in the room. HSK F reported that she did not keep track of the rooms that she does and/or doesn't mop. 35981 In an observation on 9/25/24 at 11:02 AM., noted in the shared bathroom for rooms 406/408 was a strong smell of urine. The toilet was tank was noted to be running adding water from the tank into the bowl. The water was flowing from the tank into the toilet bowl at a fast rate, and sounded like a bubbler. The toilet seat was heavily soiled/stained with a yellow/orange color. Noted on the toilet seat were yellow half dried drops of urine, and feces was noted on the inside rim of the toilet seat. The caulking around the base of the toilet was noted to be heavily soiled with a dark yellow/brown dried substance that appeared to be a heavy accumulation of dried urine. In an observation on 9/26/24 at 9:40 AM., noted the bed in room [ROOM NUMBER] stabilizer bars on both sides of the bed were noted to be heavily soiled with stuck on dried, crusty substances. The bedside table was noted to be soiled on the table top with food crumbs and dried sticky cup rings. The frame of the bedside table had dried stuck on food and the base of the table was noted to be heavily soiled with dirt, dust and stuck on substances. (continued on next page)

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