STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Rd Alpena, MI 49707

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on interview and record review, the facility failed to recognize a change in condition for one Resident (R70) out of 23 residents reviewed for quality of care. This deficient practice resulted in hospitalization and death. Findings include: Resident #70 (R70) Review of the admission record for R70, revealed an original admission to the facility on [DATE], with medical diagnoses including congestive heart failure (heart does not pump or fill adequately), chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), morbid obesity, and muscle weakness. Review of progress note, dated [DATE] at 11:08 AM, read in part, .Resident admits to SNF (skilled nursing facility) for short term rehab . Review of physician progress note, dated [DATE] at 12:30 PM, read in part, .His goal is to rehab and discharge to home . Review of medication administration record (MAR), dated [DATE] through [DATE], revealed the following lab orders: a.) [DATE] - Lab to draw CBC (complete blood count) [identifies and counts the seven types of cells found in the blood], BMP (basic metabolic panel) [provides information about chemical balances and metabolism in the blood], Iron Studies [measures the iron in blood], and HgbA1C [measures the average blood sugar (glucose) level over the past two to three months]. b.) [DATE] - Lab to draw CBC, BMP, and Iron Studies. Review of R70's labs, drawn on [DATE], revealed the following: a.) CMP (comprehensive metabolic panel) [measures the bodies fluid balance, levels of electrolytes, and how well the kidneys and liver are functioning] - BUN (blood urea nitrogen) 38 mg/dL (milligrams per deciliter) high (normal range is 9 to 20) [measures how well the kidneys are functioning], Serum Creatinine 1. 49 mg/dL high (normal range is 0.66 to 1.25 / measures how well kidneys are functioning), Calcium 7.3 mg/dL low (normal range is 8.4 to 10.2), and Sodium 128 mg/dL low (normal range is 137 to 145). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	b.) BNP, NT pro (natriuretic peptide test) [measures a protein called BNP in the blood and can be a sign and indicator of severity of heart failure] - BNP, NT pro 5,020 pg/mL (picograms per milliliter) elevated [normal range is < 300]. *Note highly elevated lab value. c.) Lab CBC with differential [measures white blood cell counts] - WBC's 0.9 K/uL (Kilo/microliter) low [normal range is 3.5 to 11.0], RBC's 3.36 M (million)/uL low [normal range is 4.10 to 5.70], Hemoglobin 9.3 G (Grams)/DL low [normal range is 13.5 to 17.0], and Hematocrit 28.3 low [normal range is 40.0% to 50.0%]. *Notation on lab work by Registered Nurse (RN) Q, revealed doctor made aware at 10:00 PM on [DATE] (no new orders noted in progress notes or on printed lab results). Signed off by doctor not dated. Providers (nurse practitioner into see R70 on [DATE] - no notes regarding labs or follow up and doctor into see R70 on [DATE] - no notes regarding labs or follow up). Review of R70's labs, drawn on [DATE], revealed the following: Lab CBC with differential - WBC's 0.9 K/uL low, RBC's 3.33 M/uL low, Hemoglobin 9.4 G/DL low, and Hematocrit 29.7 low. *Note R70 history of CHF and no follow up BNP on this date. Review of R70's labs, drawn on [DATE], revealed the following: Lab CBC with differential - WBC's 0.9 K/uL low, RBC's 3.31 M/uL low, Hemoglobin 9.7 G/DL low, and Hematocrit 29.5 low. *Note R70 history of CHF and no follow up BNP on this date. Review of blood pressure and pulse, dated [DATE] through [DATE], revealed the following: a.) On [DATE] at 2:46 PM - blood pressure ,d+[DATE] and pulse 94. b.) No blood pressure or pulse documented on [DATE], [DATE] or [DATE]. c.) On [DATE] at 10:55 AM - blood pressure ,d+[DATE] and pulse 88. d.) On [DATE] at 2:54 PM - blood pressure ,d+[DATE] and pulse 97. e.) On [DATE] at 3:59 PM - blood pressure ,d+[DATE] and pulse 106. f.) No blood pressures or pulse documented for [DATE]. g.) On [DATE] at 11:17 AM - blood pressure ,d+[DATE] and pulse 113. h.) On [DATE] at 10:00 AM - blood pressure ,d+[DATE] and pulse 128. *Note a follow up set of vital signs should have been repeated on [DATE] at approximately 7:00 PM and then again at 11:00 PM and none were obtained per algorithm of sepsis that was initiated on [DATE]. The blood pressures and pulses above were not repeated on [DATE] or documented as communicated to the physician from nursing. On [DATE] no sepsis pathway screening was completed with R70's decreased blood pressure and increased pulse. Review of facility document titled, Sepsis Pathway, no dated, revealed the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a.) Sepsis vital signs include - WBC [white blood cell count] > 12,000 or < 4,000, temperature > 100.0 or < 96. 0, or increase > 2 degrees F (Fahrenheit) above baseline, heart rate > 90, respiratory rate > 20, and if a resident has an increased baseline change heart rate > 110 and respiratory rate > 25. b.) According to the sepsis pathway algorithm if R70 met one sepsis vital sign to continue through the pathway. Then to call the physician. Next screen the (urine, chest x-ray or lab [CBC], monitor for vital signs, blood pressure, pulse oximetry every four hours times four, and to notify primary physician of any changes. c.) According to the sepsis pathway algorithm if R70 met two sepsis vital signs to call physician. Then initiate treatment within four hours with intravenous fluids, obtain blood cultures times two, CBC with differentials, BMP, and Lactate [measures the amount of lactic acid in the blood], start antibiotic protocol. Continue to monitor the vital signs, blood pressure, pulse oximetry every two hours times four, and to notify primary physician of any changes Finally, transfer to hospital if systolic blood pressure is < 90, end organ dysfunction, progress to three sepsis vital signs. Review of R70's situation, background, assessment, and recommendation (SBAR), dated [DATE] at 3:17 PM (effective date and time), revealed in the 'situation' section, a change in condition of worsening wounds and decrease in blood pressures that started on [DATE], and indicated since initial discovery, these findings had gotten worse. Vital signs dated as most recent for [DATE] at 2:54 PM were as follows: a.) Blood pressure ,d+[DATE], pulse 97, respiratory rate 16, temperature 97.8 - date obtained [DATE] at 2:54 PM, and weight 410.0 pounds - date obtained [DATE] at 3:46 PM. b.) Sepsis pathway worksheet - marked as negative. *Note marked incorrectly and should have been marked positive with relevant information obtained on [DATE] with blood pressure ,d+[DATE], labs drawn [DATE] white blood cell counts below 400 and vitals should have continued every 4 hours x 4 unless continued to be out of range then more monitoring should have continued. c.) Documentation of SBAR under section R tilted Request, item number 6 was dated and timed [DATE] at 7:00 AM (indicating that was the original time the SBAR was filled out). *Note making it difficult to discern what time the actual event started to occur. Review of R70's physician progress note, dated [DATE], read in part, .Nursing to update with changes/concerns. Review of R70's task for amount eaten, dated [DATE] through [DATE], revealed that on [DATE] no food intake was consumed and marked as resident refused breakfast and dinner and lunch zero intake recorded, on [DATE] refused breakfast and dinner and lunch only ate half, and on [DATE] refused breakfast. Review of R70's SBAR, dated [DATE] at 10:27 AM (effective date and time), revealed in the 'situation' section a change in condition of hypotension, tachycardia, slow speech and verbal response. Inappropriate responses/using the wrong words during interaction, refusing meals. Vital signs dated as most recent for [DATE] at 10:00 AM were as follows: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a.) Blood pressure ,d+[DATE], pulse 128, respiratory rate 16, temperature 97.5 and (weight 410.0 pounds - dated [DATE] at 3:46 PM). b.) Mental status changes - increased confusion. d.) Sepsis pathway worksheet - marked as negative. *Note marked incorrectly and should have been marked positive with relevant information obtained on [DATE], and labs drawn on [DATE] white blood cell counts below 400. c.) Assessment - Sepsis, several non-healing wounds. d.) Nursing notes - Spoke with (resident's name) regarding his vital signs and educated on s/s (signs and symptoms) of sepsis. (Resident's name) stated he was willing to go to the hospital. e.) Documentation of SBAR under section R tilted Request, item number 6 was dated and timed [DATE] at 10:45 AM (indicating that was the original time the SBAR was filled out). *Note making it difficult to discern what time the actual event started to occur. On [DATE] at 4:11 PM, during a telephone interview, Licensed Practical Nurse (LPN) R was asked if she recalled R70 and acknowledged; The blood pressure was low, but I didn't feel he had a change of condition, so I did not call the doctor. *Note vital signs on [DATE] when LPN R worked were as follows: On [DATE] at 11:17 AM - blood pressure ,d+[DATE] and pulse 113. On [DATE] at 10:45 AM, an interview with RN Q was conducted. RN Q was asked about sepsis protocol, and replied, Nurses follow the pathway and call the physician. RN Q was asked if she correctly filled out the SBAR sepsis screening dated [DATE]. After reviewing it with this Surveyor RN Q replied, Apparently not. RN Q was then asked if R70 was diabetic and replied, No. I guess I should have checked his blood glucose too. I was just trying to get him out. Me not doing that did not make any difference. He got sent out anyway. Review of R70's local emergency medical services (EMS) transport run sheet, dated [DATE], revealed the following: a.) Call received 11:08 AM b.) On scene 11:16 AM c.) Pulse 120 at 11:22 AM d.) Blood pressure ,d+[DATE] at 11:25 AM e.) Intravenous site placed successful at 11:30 AM with fluid challenge initiated (20 gauge right antecubital [inner elbow/bend of arm]). f.) Blood pressure ,d+[DATE] at 11:32 AM g.) Respirations 28 at 11:36 AM (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	h.) Narrative history: Dispatched via 911 to the above locations for the above patient for possible sepsis. The patient was admitted to the SNF (skilled nursing facility) on [DATE]th. The patient has multiple non healing wounds on his buttocks, as well as his legs, some are from pressure, some are venous insufficiency. i.) Unable to sign - comment: Patient is alert, and in critical condition. Review of R70's local hospital admission documentation, dated [DATE] through [DATE], revealed the following: a.) admitted to emergency department (ED) in room [ROOM NUMBER] on [DATE] at 11:41 AM b.) Vital signs in ED: Pulse 129, respirations 26, and blood pressure ,d+[DATE] c.) Physician exam in ED: He is ill-appearing and toxic appearing. d.) ED course note: Patient is seen and evaluated upon arrival. He does state that he would want medication to keep his blood pressure at a normal level. e.) Hospital labs drawn in ED on ,d+[DATE] that were found abnormal: 1.) pro-BNP 21,400 2.) Lactate 2.6 (normal values are below 0.5 and values >0.5 to 2.0 suggest an intermediate likelihood of sepsis and/or septic shock) 3.) A second lactate was drawn and resulted as 4.8 4.) A third lactate was drawn and resulted as 8.4 5.) Procalcitonin 5.26 (a serum biomarker that helps distinguish bacterial infection from other causes of infection) Serum concentrations are normally <0.5, and >2.00 are high risk of sever sepsis and/or septic shock. 6.) BUN 113 7.) Creatinine 3.69 8.) WBC 1.4 9.) Arterial blood gases: pH 7.16, pCO2 39, pO2 27, HCO3 13.3, and O2 Sat. 28 (measure oxygen and carbon dioxide in the blood) R70's lab values indicate metabolic acidosis (a condition where too much acid accumulates in the blood). This condition is treated with intravenous fluids, bicarbonate, and possibly hemodialysis (mechanical blood filtration). f.) admitted to intensive care unit (ICU) on [DATE] at approximately 4:02 PM (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	g.) Hospital medications included but not limited to cefepime (antibiotic), sodium chloride 2.5 liters (intravenous fluids to support body fluid volume), vancomycin (antibiotic), amiodarone (antiarrhythmic to help control fast heart rate), hydrocodone (narcotic pain medication), morphine (opioid pain medication), norepinephrine (sympathomimetic/helps to increase blood pressure back to a normal range), phenylephrine (vasoconstrictor/used to treat septic and neurogenic shock and hypotension), piperacillin-tazobactam (antibiotic), and vasopressin (antidiuretic hormone/used to increase blood pressure). h.) Discharge summary: admitted to ICU for septic shock and presumed infected deep decubitus ulcers involving the sacrococcygeal region. Despite aggressive supportive care directed at his sepsis including multiple vasopressors, systemic steroids, fluids, antibiotic therapy the patient's condition declined. He passed away early the morning of [DATE] (approximately 13 hours after he was admitted). Review of hospital history and physical, dated [DATE], read in part, .Chief complaint: General malaise . multiple poor healing wounds .He has been on cephalexin long-term .He states his appetite has been down . Decubitus ulcers about his sacral region are deep and malodorous .Weight [DATE] at 11:50 AM resulted as 409 pounds and at 4:25 PM resulted at 389 pounds .eyes were sunken .edema present in bilateral lower extremities .multiple skin tears and pressure ulcerations/decubitus are noted about his sacrococcygeal area, abdominal wall and lower extremities. See pictures .Principal problem: Septic shock source felt to be decubitus ulcers .Decubital ulcer concerns related to deep infection as evidence by his clinical presentation and odor emanating from the wound .Cellulitis and abscess of buttocks concerns related to deep infection as evidence by his clinical presentation and odor emanating from the wound . Review of hospital nursing notes, dated [DATE], read in part, Doctor .called to bedside many times through the night, patient going in and out of SVT (supraventricular tachycardia a heart rate > 150 beats per minute), maxed on norepinephrine, vasopressin, and phenylephrine. Amiodarone drip running. Central line placed. Unable to obtain an arterial line placement. Time of death 12:32 AM . Review of a hospital progress note, dated [DATE], read in part Called to ICU on [DATE] at 11:03 PM regarding patient not doing well having runs of tachycardia (rapid heartbeat >170 beats per minute) .Patient's extremities lower are (sic) have mottled appearance (a bluish-red, laced-like pattern under the skin/deoxygenated blood pools beneath the skin's surface). Patient with ongoing hypotension (decrease blood pressure) on norepinephrine and vasopressin. Added phenylephrine to try titrate down norepinephrine. Patient with ongoing clinical decline despite max medical support. Patient passed away on [DATE] at 12:32 AM. On [DATE] at 3:30 PM, an interview was conducted with RN/Infection Control H and was asked if R70's wound had ever been swabbed for culture and replied, Never had a swab to clarify what bacteria he had from his wounds or the weeping of serious fluid. He was put on Hospice related to his wounds recommended by doctor at the wound clinic. On [DATE] at 10:27 AM, an interview was conducted with the DON and was asked if R70 was on the same antibiotic each time he had a skin infection and replied, He was not on the same antibiotic. He was started on a 20-day course because he was on it before, and it worked. The DON went on to explain that R70's wound was not cultured at all. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 10:50 AM, during an interview, the DON was asked about the sepsis pathway and if it was comparable to the charting that was on the electronic medical record and replied, Yes. We collaborated with the local hospital to develop the Sepsis Pathway/screening tool. The DON was asked about R70's SBAR (situation, background, assessment, and recommendation) dated [DATE] and replied, I don't' know what time the documentation was completed. It was locked on the 11th. The vital signs should have been from the 10th and not the 11th. The DON confirmed that the sepsis screening tool was improperly filled out and she should have checked R70's blood glucose level and reviewed most recent labs. The DON stated, The only thing I felt was a change was his heart rate. The DON was then asked if there was any reason why R70 did not have increased monitoring of vital signs if he had a change in condition and was suspected to have sepsis and replied, He was on pertinent charting for infection already. The DON was then asked about R70's lactic acid level and replied, To be septic you have to be 4.3, and lactic acid was 2.6. *Notes according to the National Library of Medicine the normal lactic acid level is < 0.5 ng/mL (nanograms per milliliters), and a value of 2.0 ng/mL suggests a significantly increased risk of sepsis and/or septic shock. The DON further explained that R70 developed wounds and thought he was dying. He had all these things going on. I think he was dying. The DON was asked if R70 ever told her he wanted to die and replied, No. He did not say he wanted to die. He was non-adherent. On [DATE] at 11:57AM, a telephone interview was conducted with Nurse Practitioner (NP) T and was asked about R70 and the low blood pressure and increased pulse he had on [DATE] and [DATE]. NP T replied, He should have been more closely monitored after the change in condition on [DATE]. The nurses should have been getting a set of vital signs at minimum every shift. On [DATE] at 2:16 PM, an interview was conducted with Physician U who stated, I don't know if they called me on [DATE] regarding the low vitals, but they said they repeated them on [DATE] and they were normal. Regarding the lab work and no follow-up labs in June, he refused and that was indicated on the lab sheet. The wound was cultured, and I stuck a swab around, but it was dry, and I would have made a note in my documentation when I saw him. Looking back, I felt the nurses could have had better documentation. *Note reviewed physician rounding notes and found no supporting documentation that the wound was ever cultured or attempted to be cultured. Wound evaluations indicated moderate amounts of drainage. Lab sheets were reviewed and no written documentation of a refusal for lab draws was found. Review of R70's death certificate, dated [DATE], revealed R70 died from septic shock from infected sacral wounds and congestive heart failure on [DATE]. Review of policy titled, Notification of Changes, dated [DATE], read in part, Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority resident's representative when there is a change requiring notification For changes of condition the facility may use: 1. SBAR (Situation, Background, Assessment, and Recommendation) process for assessment .3. Sepsis protocols. Circumstances requiring notification include . 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications . *Note requested skilled nursing assessment notes from when R70 was on skilled charting to review any education that was provided to R70 regarding cares, and none was received at the time of survey exit.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review the facility failed to prevent the development of pressure wound for two Residents (R33 & R70) out of three residents reviewed for pressure ulcer care. This deficient practice resulted in deterioration of pressure wound, sepsis, and hospitalization , requiring wound debridement for R70. Findings include: Resident #70 (R70) Review of the admission record for R70, revealed an original admission to the facility on [DATE], with medical diagnoses including congestive heart failure (heart does not pump or fill adequately), chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), morbid obesity, and muscle weakness. Review of R70's progress note, dated 3/11/24 at 11:08 AM, read in part, .Resident admits to SNF (skilled nursing facility) for short term rehab . Review of R70's physician progress note, dated 3/11/24 at 12:30 PM, read in part, .His goal is to rehab and discharge to home . Review of R70's admission skin assessment, dated 3/11/24, completed by LPN (Licensed Practical Nurse)/Unit manager L, revealed the following left lateral ribs weeping and right great toe two small, dried blood blisters. *Note no other skin impairments or open areas identified on admission. On 7/30/24 at 4:00 PM, an interview was conducted with LPN L, who was asked what kind of intervention was put into place for R70 related to the left lateral ribs weeping and replied, I wiped it off at the time of the skin assessment. I don't know if it started weeping again. I did not put any interventions in place. I did not feel he needed any. Review of R70's skin inspection shower documentation, dated 3/19/24, revealed excoriation and reddened areas on the groin and buttocks and signed off by an unidentified nurse's initials. Review of R70's interdisciplinary progress note, dated 3/20/24, read in part, .MASD (moisture associated skin damage) to rear medial left thigh. Area measures 7.7 x 1.4 x 0.1 (centimeters) .occasional incontinence . An admission MDS (Minimum Data Set) assessment, dated 3/17/24, section E0800, read in part, .Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being . Behavior not exhibited .section M skin conditions, revealed R70 was at risk for developing pressure ulcers and had no unhealed pressure ulcers . An MDS assessment, dated 6/17/24, section E0800, read in part, .Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being .Behavior not exhibited .section M skin conditions, revealed R70 had a stage 1 or greater pressure ulcer, was at risk for developing pressure ulcers, and had two stage 3 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(full thickness tissue loss) pressure ulcers that were not present on admission . Review of R70's skin and wound evaluation, dated 4/11/24 through 5/29/24 revealed the following: Wound #3- a.) 4/11/24 - Wound #3 undiagnosed , rear left flank/lateral, minutes old, in house acquired, and measured 1. 56 L (length) x 0.79 W (width) cm. b.) 4/30/24 - Wound #3 MASD, rear left flank/lateral, 1 month old, and measured 0.73 L x 2.17 W x 0.2 D (depth) cm c.) 5/7/24 - Wound #3 MASD, rear left flank/lateral, 1 month old, and measured 1.21 L x 2.77 W x 0.4 D cm d.) 5/14/24 - Wound #3 MASD, rear left flank/lateral, 1 month old, and measured 1.7 L x 3.23 W x 0.3 D cm e.) 5/21/24 - Wound #3 MASD, rear left flank/lateral, 1 month old, and measured 2.45 L x 3.14 W x 2.3 D cm f.) 5/24/24 - Wound #3 MASD, rear left flank/lateral, 1 month old, and measured 2.17 L x 3.83 W x 3.0 D cm g.) 5/29/24 - Wound #3 MASD, rear left flank/lateral, 1 month old, and measured 2.53 L x 4.11 W x 4.5 D cm, and with undermining 0.3 cm from 1 to 2 o'clock. Wound #4- a.) 4/11/24 - Wound #4 Pressure - unstageable, right ischial tuberosity (bony prominence on buttocks), 4 hours old, in house acquired, and measured 1.64 L x 1.29 W cm b.) 4/16/24 - Wound #4 Pressure - unstageable, right ischial tuberosity, 4 hours old, in house acquired, and measured 2.29 L x 1.32 W x 0.2 D cm c.) 4/23/24 - Wound #4 Pressure - unstageable, right ischial tuberosity, 4 hours old, in house acquired, and measured 1.67 L x 1.25 W cm *Note picture shows depth, but none was measured d.) 4/30/24 - Wound #4 Pressure - unstageable, right ischial tuberosity, 4 hours old, in house acquired, and measured 1.08 L x 1.74 W x 0.2 D cm e.) 4/30/24 - Wound #4 Pressure - stage 3, right ischial tuberosity, 4 hours old, in house acquired, and measured 1.44 L x 1.75 W x 0.4 D cm f.) 5/14/24 - Wound #4 Pressure - stage 3, right ischial tuberosity, 4 hours old, in house acquired, and measured 2.0 L x 2.19 W x 0.3 D cm (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	g.) 5/21/24 - Wound #4 Pressure - stage 3, right ischial tuberosity, 4 hours old, in house acquired, and measured 2.56 L x 2.54 W x 2.0 D cm, and moderate serosanguineous drainage h.) 5/24/24 - Wound #4 Pressure - stage 3, right ischial tuberosity, 4 hours old, in house acquired, and measured 2.31 L x 2.37 W x 1.5 D cm, undermining 0.2 cm, and moderate serosanguineous drainage with a faint odor i.) 5/29/24 - Wound #4 Pressure - stage 3, right ischial tuberosity, 4 hours old, in house acquired, and measured 3.05 L x 2.4 W x 0.3 D cm, undermining 0.3 cm, and moderate serosanguineous drainage with a faint odor. Wound #6- a.) 5/21/24 - Wound #6 Pressure - stage 3, right iliac crest, age unknown, in house acquired, and measured 1.13 L x 1.1 W x 0.2 D cm b.) 5/24/24 - Wound #6 Pressure - stage 3, right iliac crest, age unknown, in house acquired, and measured 2.39 L x 1.45 W x 0.2 D cm c.) 5/29/24 - Wound #6 Pressure - stage 3, right iliac crest, age unknown, in house acquired, and measured 2.81 L x 2.1 W x 0.1 D cm. Wound #7- a.) 5/21/24 - Wound #7 Open lesion, coccyx - middle, age unknown, in house acquired, and measured 1.42 L x 0.67 W x 0.2 D cm b.) 5/24/24 - Wound #7 Open lesion, coccyx - middle, age unknown, in house acquired, and measured 0.6 L x 0.3 W cm c.) 5/29/24 - Wound #7 Open lesion, coccyx - middle, age unknown, in house acquired, and measured 3.73 L x 0.33 W x 0.1 D cm. Review of R70's skin and wound evaluation, dated 7/10/24, revealed the following: a.) Wound #11 Pressure - Stage 3, right ischial tuberosity (second open area to this locations), new - 21 hours old, in house acquired, and measured 1.5 L x 0.56 W x 0.2 D cm. A wound clinic progress note, dated 6/3/24, read in part, .patient presents to the wound care center today as a New patient for multiple wounds on multiple areas on his body .One wound is on his torso started as weeping which did created (sic) a ulcer since in SNF (skilled nursing facility) .He also has one on his right gluteal fold that was discovered by staff at SNF this had a wound vac on .Debridement done on all wounds today . Further review of the wound clinic note revealed the following - wound on right gluteus, right hip, sacrum, and left gluteus: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a.) The date acquired was: 5/6/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Right Sacrum. The wound measures 0.9 cm length x 1.2 cm width x 0.4 cm depth. There is a medium amount of serosanguineous drainage noted. There is a small (1-33%) red granulation within the wound bed. There is a large (67-100%) amount of necrotic tissue within the wound bed including Adherent Slough. b.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Right Gluteal fold. The wound measures 2.5 cm length x 1.6 cm width x 0.4 cm depth. There is a medium amount of serosanguineous drainage noted. There is a small (1-33%) red granulation within the wound bed. There is a large (67-100%) amount of necrotic tissue within the wound bed including Adherent Slough. c.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Left Lateral Back. The wound measures 2.2 cm length x 3.5 cm width x 2.5 cm depth. There is tunneling at 12:00 with a maximum distance of 1 cm. There is a medium amount of serosanguineous drainage noted. There is a small (1-33%) red granulation within the wound bed. There is a large (67-100%) amount of necrotic tissue within the wound bed including Adherent Slough. d.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Right Lateral Back. The wound measures 0.1 cm length x 0. 2 cm width x 0.5 cm depth. There is a medium amount of serosanguineous drainage noted. There is a small (1-33%) red granulation within the wound bed. There is a large (67-100%) amount of necrotic tissue within the wound bed including Adherent Slough. A wound clinic progress note, dated 6/12/24, read in part, .Patient presents to wound center today for follow-up evaluation and management of a (sic) ulcer on his buttock as well as an ulcer on his left lateral abdomen. Upon evaluation at today's encounter the buttock ulcer is full-thickness, there is devitalized tissue and slough within the ulcer .Patient agreed and debridement was accomplished. There is undermining at this ulcer .Patient stated the debridement was very painful and he also states that simple palpation causes extreme pain in the area . Further review of the wound clinic note revealed the following wound measurements: a.) The date acquired was: 5/6/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Right Sacrum. The wound measures 0.7 cm length x 0.9 cm width x 0.507 cm depth. There is a medium amount of serosanguineous drainage noted. b.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Right Gluteal fold. The wound measures 1.2 cm length x 1.2 cm width x 1.197 cm depth. There is a medium amount of serosanguineous drainage noted. c.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Left Lateral Back. The wound measures 1.5 cm length x 3.5 cm width x 4.096 cm depth. There is tunneling. There is a medium amount of serosanguineous drainage noted. *Note wounds had worsened and increased in size from prior visit on 6/3/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A wound clinic progress note, dated 6/26/24, read in part, .Patient presents to wound center today for follow-up. Wounds today are stable. Unable to evaluate sacrum wound based on limited mobility. Debridement completed on wounds today . Further review of the wound clinic note revealed the following wound measurements: a.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Right Gluteal fold. The wound measures 2.8 cm length x 1.3 cm width x 0.4 cm depth. There is a medium amount of serosanguineous drainage noted. b.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Left Lateral Back. The wound measures 2.6 cm length x 4.8 cm width x 3.2 cm depth. There is tunneling. There is a medium amount of serosanguineous drainage noted. c.) The date acquired was: 4/8/24. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Right Lateral Back. The wound measures 0.5 cm length x 0. 5 cm width x 0.2 cm depth. *Note: Plan follow-up appointment - return in 1 week. *Note wounds had worsened and increased in size from prior visit on 6/12/24. Review of R70's care plan, dated 3/12/24, read in part, .Focus: Resident is at risk for impaired skin integrity related to Morbid Obesity, CHF, Muscle Weakness, Braden Score 15. Goal: Resident will have intact skin . Interventions .Low air loss mattress (4/11/24) .If resident refuses interventions/treatments, encourage compliance to minimize further skin impairment (3/19/24) .Provide incontinence care as needed (3/19/24) . Assist resident with turning and repositioning as needed (3/19/24) . Review of R70's progress note, dated 4/11/24, read in part, Resident is noted to have 2 new areas of impairment. Resident has an abrasion on his left rear lateral flank that measures 1.6 cm x 0.8 cm x 0.1 cm. He has an unstageable pressure ulcer on his R (right) ischial tuberosity measuring 1.6 cm x 1.3 cm x 0.1 cm . A LALM (low air loss mattress) was ordered and resident is refusing at this time .[R70 stated] I have a call in 7 minutes that I have to be back in bed for. This writer asked if we would be able to place LALM later in the day today after his call. He sighed and asked if he had to get out of bed for this writer stated yes. He stated, This will just have to be done tomorrow then. A physician order for R70, dated 4/11/24, revealed low air loss mattress and was discontinued on 4/11/24. A physician order for R70, dated 4/25/24, revealed low air loss mattress was reordered. *Note a lack of explanation as to why the low air loss mattress was not initiated on the following Monday on 4/15/24. Review of R70's progress note, dated 4/25/24, read in part, .Maintenance was notified and placed a bari (bariatric)-LALM. Orders placed . A physician progress noted, dated 5/1/24, read in part, Patient continues participating with therapy as ordered. Staff has noted a new abrasion to sacrum today, treatment in place and appropriate .No changes to plan of care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A nurse practitioner progress note, dated 5/15/24 (late entry), read in part, Patient continues participating with therapy as ordered. Nursing monitors and treats abrasion to sacrum, treatment in place and appropriate. New R (right) iliac crest wound noted during care. Tx (treatment) ordered and appropriate .No changes to plan of care. Review of R70's interdisciplinary progress note, dated 5/16/24, read in part, .In regards to his mood, the resident stated that he was an attorney in (City Omitted) for 245 (sic) years, and that he is used to a very short and to the point manner of conversation. He also stated that even as a child he was not very social. The resident stated he is not to the social culture of the Midwest where people are very friendly and caring, and that where he is from the people just say what they want/need, without much small talk . Review of R70's interdisciplinary progress note, dated 5/22/24, read in part, During weekly assessment of residents wounds it has been noted that wounds are showing s/s (signs and symptoms) of infection. Wounds appear to have increased purulent drainage, increased redness, and are worsening . A physician progress note, dated 5/22/24, read in part, Patient is participating with therapy as ordered. Patient is on [brand name antibiotic] cephalexin regimen for wound are (sic) until 5/31 .Provider orders staff to call wound clinic .open wounds . Review of R70's progress note, dated 5/23/24, read in part, .Was upset when I brought him his 1400 (2:00 PM) medicine, I explained that he asked me to change it till (sic) this time he was fine with it . Review of R70's progress note, dated 5/28/24 at 2:51 PM, read in part, .copious drainage, tender with dressing changes . Review of R70's progress note, dated 5/28/24 at 2:53 PM, read in part, .He stated that when he is positioned on his side, he feels bed frame . *Note no explanation as to why R70 felt the bed frame or indication of poor repositioning. Review of R70's interdisciplinary progress note, dated 5/29/24, read in part, .Times of medications have been adjusted per residents' preferences and he continues to complain, once reminded he becomes more understanding . A physician progress note, dated 6/3/24 (late entry), read in part, Patient has completed [brand name antibiotic] cephalexin regimen for wound care. Has been referred to wound clinic . Review of R70's physician progress note, dated 6/14/24, read in part, Patient seen for nursing reporting left side is weeping. Left hip with edema, light drainage .Last day of OT (occupational therapy currently ordered for the 15th . Review of R70's progress note, dated 6/17/24, revealed, While I was in room with am meds, I inquired about staff offering to change bed linens and complete hygiene cares. [R70] replied that it can wait til (until) tomorrow. MASD education provided and [R70] then agreed it can be done sometime today. *Note when R70 was reapproached with educated and explanation given in this progress note he became compliant with cares at that time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A physician progress note, dated 6/28/24, read in part, Patient is seen for concern of recurrence of cellulitis to right ankle .He reports worsening of discomfort since completion of [brand name antibiotic] cephalexin earlier this month .Orders given for cephalexin .for cellulitis of Right foot and ankle .wound clinic follow up. Review of R70's progress note, dated 7/2/24, read in part, Resident refused treatments for wound change due to pain. Medication is being ordered to be given 1 hour prior to wound change for tomorrow . Review of R70's progress note, dated 7/3/24, revealed, [R70] was very pleasant and cooperative with staff today. Pain med given prior to dressing changes and very effective. Review of R70's behavior progress note, dated 7/4/24, revealed, Remained appropriate with all Interactions. He was aware a dressing change was going to be completed to his L (left) side. I noticed that the dressing to his coccyx was coming loose and removed dressing. [R70's name] responded you're not changing that one. I informed him that it needed to be changed, he was no longer resistant. Review of R70's physician order, dated 4/4/24, revealed the following order cephalexin oral capsule 500 mg (milligram), give 2 capsules by mouth two times a day for LLE (left lower extremity) cellulitis for 10 days. Review of R70's physician order, dated 5/21/24, revealed the following order cephalexin oral capsule 500 mg (milligram), give 2 capsules by mouth two times a day for wounds for 10 days. Review of R70's physician order, dated 6/30/24, revealed the following order cephalexin oral capsule 500 mg (milligram), give 2 capsules by mouth two times a day for cellulitis to R (right) lat (lateral) malleolus for 20 days. All R70's occupational therapy (OT) progress notes were reviewed, dated 4/17/24 through 5/20/24, revealed the following 25 treatment opportunities with 20 great and or good participation, 2 refusals, 2 actively participates, and 1 needs encouragement. All R70's physical therapy (PT) progress notes were reviewed, dated 4/17/24 through 5/20/24, revealed the following 25 treatment opportunities with 10 active participation, 11 compliant, 2 moderate encouragements, 1 needed extra time procession new information, and 1 refusal related to not feeling well. A PT progress note, dated 5/6/24, read in part, .Demonstrates some slurred words and potential altered mental status - reported to nursing for further evaluation. Additionally, pt (patient) brought up ideations about dying and suicidal thoughts which were also reported to nursing and social work. *Note social services notes were reviewed and no social service note found on or within a few days of R70 voicing such thoughts. Review of R70's turning and repositioning every shift documentation, dated 3/20/24 through 3/31/24, revealed the following: 4 indicating refusal of turning, 4 not filled out and blank on the 10 to 6 shift, and overall, 4 turning and repositioning refusals out of 32 opportunities. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R70's target behavior documentation, dated 3/20/24 through 3/31/24, revealed the following: 5 indicating behaviors, 3 not filled out and blank on the 10 to 6 shift, and overall, 5 behaviors out of 32 opportunities. Review of R70's turning and repositioning every shift documentation, dated 4/1/24 through 4/30/24, revealed the following: 1 indicating refusal of turning, 3 not filled out and blank on the 10 to 6 shift, and overall, 1 turning and repositioning refusals out of 90 opportunities. Review of R70's target behavior documentation, dated 4/1/24 through 4/30/24, revealed the following: 8 indicating behaviors, 8 not filled out and blank on the 10 to 6 shift, and overall, 5 behaviors out of 90 opportunities. Review of R70's turning and repositioning every shift documentation, dated 4/1/24 through 4/12/24 (changed to every two hours at 2:00 PM on 4/12/24), revealed the following: 2 indicating refusal of turning, 3 not filled out and blank on the 10 to 6 shift, and overall, 2 turning and repositioning refusals out of 34 opportunities. Review of R70's target behavior documentation, dated 5/1/24 through 5/31/24, revealed the following: 7 indicating behaviors, 9 not filled out and blank on the 10 to 6 shift, and overall, 7 behaviors out of 93 opportunities. Review of R70's target behavior documentation, dated 6/1/24 through 6/30/24, revealed the following: 11 indicating behaviors, 13 not filled out and blank, and overall, 11 behaviors out of 90 opportunities. Review of R70's target behavior documentation, dated 7/1/24 through 7/15/24, revealed the following: 8 indicating behaviors, 4 not filled out and blank, and overall, 8 behaviors out of 43 opportunities. *Note R70 did have some resistance to cares at times, but over all did not show indefinite non-compliance or consistent behaviors. On 7/31/24 at 4:11 PM, a telephone interview was conducted with LPN R and was asked about R70 and his wounds and replied, We had to give him pain medicine prior to wound care. We would have to go in there with multiple, multiple people. The last time I did them I did them all. The facility wound nurse did the wound care on Tuesday, staff nurses did wound care the rest of the week. One Tuesday he didn't let them get done. He didn't like people in the room. I think he was working. Left side, buttocks, and one on his right leg. We had to do it so quick there was no looking - he was screaming the whole time in pain. On 7/31/24 at 3:30 PM, an interview was conducted with RN/Infection Control H and was asked if R70's wound had ever been swabbed for culture and replied, Never had a swab to clarify what bacteria he had from his wounds or the weeping of serious fluid. He was put on Hospice related to his wounds recommended by doctor at the wound clinic. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/1/24 at 10:27 AM, an interview was conducted with the DON and was asked if R70 was on the same antibiotic each time he had a skin infection and replied, He was not on the same antibiotic. He was started on a 20-day course because he was on it before, and it worked. The DON went on to explain that R70's wound was not cultured at all. Not even from the wound clinic. The DON also explained that R70 was still working from his laptop in his room but was not sure what kind of work and did acknowledge he had a zoom meeting and important phone calls during his stay at the facility. On 8/1/24 at 10:50 AM, an interview with the DON and was asked about the development of R70's wounds and replied, We thought he was dying. He had all these things going on. I think he was dying. The DON was asked if R70 ever told her he wanted to die and replied, No. He did not say he wanted to die. He was non-adherent. Review of policy titled, Pressure Injury Prevention Guidelines, dated 3/20/24, read in part, Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for residents who are assessed at risk or who have a pressure injury present . Review of policy titled, Pressure Injury Prevention and Management, dated 1/1/22, read in part, Policy: This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries . Review of policy titled, Antibiotic Prescribing Practices, dated 10/26/23, read in part, Policy: Antibiotic use protocols, including prescribing practices, are implemented as part of the facility's Antibiotic Stewardship Program for the purpose of optimizing the treatment of infections and reducing adverse events associated wit antibiotic use .The facility will utilize a 5 D's approach to antibiotic prescribing: a. Diagnosis .b. Drug: The prescribed medication will be appropriate for the treatment site and identified organism. c. Dose .d. Duration . e. De-escalation: Reassessment of empiric precautions will be conducted for appropriateness and necessity, factoring in results of diagnostic tests, laboratory results, and/or changes in the clinical status of the resident. Resident #33 (R33) Review of R33's admission record, revealed an original admission to the facility on [DATE], with medical diagnoses including chronic obstructive pulmonary disease (COPD), Crohn's (bowel disorder) disease, heart failure, and hypertension. R33's admission MDS, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating severe cognitive impairment. On 7/29/24 at 2:30 PM, an observation was made of R33 lying in her bed covered with a sheet. On her nightstand there was a green pressure relieving boot green in color. On 7/30/24 at 10:08 AM, an observation of R33 receiving wound care by Registered Nurse (RN) S in her room. RN S was asked how R33 developed the pressure injury to her heel and replied, It was facility acquired. I don't think she had it when she first admitted . During the wound care treatment R33 replied, It does hurt when you touch it. I just wish the scab would fall off and it would go away. Review of R33's wound assessment, dated 5/24/24, revealed the development of a right heel pressure injury in house acquired and described as deep tissue injury, with wound measurements of 0.8 x 1.4 centimeters and no depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R33's progress note, dated 6/28/24, read in part, .Resident has a stage III pressure area to the right heel . Review of R33's wound assessment, dated 7/9/24, revealed a pressure injury stage three on the right heel, in house acquired, with measurements of 0.5 x 0.8 cm. Review of R33's MDS, section E0800, dated 5/13/24, read in part, .Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being .Behavior not exhibited . Review of R33's care plan, dated 5/2/24, read in part, .Resident has impaired skin integrity .5/24/24 R (right) heel DTI (deep tissue injury) changed to a stage 3 on 6/24/24 .Encourage/assist as needed to elevate heels off the mattress . Review of progress note, dated 7/31/24 at 9:08 AM, read in part, .A new BIMS was completed where resident was able to score a 10 . On 7/31/24 at 12:25 PM, an interview was conducted with R33 and was asked if she ever refused to wear her boot to protect her heel or decline her heels to be off the mattress and replied, I do what I am told. I didn't have to wear the boots until after the heel was hurt. I do not refuse to use the heel thing. On 7/31/24 at 12:30 PM, an interview was conducted with Certified Nurse Aide (CNA) O and was asked about R33 and replied, She uses the heels up thing and does not refuse to use it. On 7/31/24 at 12:35 PM, an interview was conducted with Licensed Practical Nurse (LPN) P and was asked about R33 and replied, I recall her being pleasant and remember she was compliant. No refusal of cares. On 7/31/24 at 12:40 PM, an interview was conducted with CNA I and was asked about R33 and replied, She was easy to take care of. She didn't give me any problems. On 7/31/24 12:50 PM, an interview was conducted with LPN/Unit Manager K and was asked when the nurses are required to start the charting on a non-compliant resident and replied, Typically as soon as we identify it. LPN K was then asked if any charting had been made prior to the development of R33's DTI and confirmed no notes prior to developing DTI. On 7/31/24 at 1:20 PM, an interview was conducted with the Director of Nursing (DON) and was asked when interventions and refusals of care should be added to the plan of care and replied, Interventions right away and refusals of care should be documented as they occur. Confirmed that no notes of refusals prior to the development of R33's DTI and more interventions should have been put into place prior to the development of her DTI. The DON confirmed there was an incident and accident report created on 5/24/24 related to R33's DTI. A copy was requested but was not received before the exit of the survey. Review of R33's task list, revealed the following: float heels implemented on 5-2-24 the day of admission, then green pressure relieving boots orders added 5-24-24 and behavior documentation (on the day the DTI developed), and then 6-4-24 the heels up device ordered.

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	235280	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Rd Alpena, MI 49707

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45123 Based on observation, interview, and record review, the facility failed to ensure a medication administration error rate of less than five percent, with three errors identified out of 25 opportunities, affecting one Resident (R10) of four residents observed for medication administration, resulting in a medication error rate of 8.00 percent. Findings include: On 7/30/24 at 11:55 AM, medication administration was observed with Registered Nurse (RN) J for R10. RN J was observed dispensing 2.5 milliliters (ml) of metoclopramide oral solution with a concentration of 5 milligrams (mg) / 5 ml. RN J was asked to verify the order and then the medication concentration. After order and medication concentration were verified, RN J replied, I need to give 2.5 ml more. I always give 2.5 ml. The order must have been changed. RN J then drew up another 2.5 ml of metoclopramide to be administered. Review of R10's physician order, dated 1/16/24, revealed the current order for metoclopramide was to give 5 ml via G-tube, three times a day for GERD (gastroesophageal reflux disease/acid reflux). On 7/30/24 at 12:20 PM, medication administration was observed with RN J in R10's room. RN J checked for placement of R10's G-tube, administered three medications (carbamazepine 10 ml, metoclopramide 5 ml, and diazepam 2 mg) and then administered tube feed. RN J was asked if she flushed R10's G-tube prior to medication administration with water and then again prior to tube feed administration and replied, I thought I did. I guess I did not. During medication administration for R10 a second Surveyor was also observing and verified RN J missed both water flushes. Review of R10's physician order, dated 8/6/23, revealed the current order for [name brand tube feeding formula] 1.5 cal (calorie), 360 ml bolus feed TID (three times a day) via gravity administration. On 7/30/24 at 12:45 PM, an interview was conducted with the Director of Nursing (DON) and was asked what her expectation was for medication administration via G-tube feeding and medication pass for G-tube and replied, I would expect that nurses follow physician orders and policy for medication pass via G-tubes. The DON was made aware of the errors that RN J had made and replied, She did fine last year. The DON verified the order for R10 and confirmed the errors. Review of policy titled, Medication Administration, dated 1/17/23, read in part, Policy: Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .10. Review MAR [medication administration record] to identify medication to be administered. 11. Compare medication source (bubble pack, vial .) with MAR to verify resident name, medication name, form, dose, route, and time . Review of facility document titled, Validation Checklist Medications via Feeding Tube, undated, read in part, . 7. Using a clean syringe (at least 30 ml syringe) administered medications appropriately, flushing prior to and between medications using at least 15 ml water flush before each medication .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49735 Based on observation, interview, and record review the facility failed to provide food in a manner that was a palatable (preferable) temperature for 19 of 23 residents interviewed. This deficient practice resulted in frustration with meals and the potential for weight loss and inadequate nutrition. Findings include: During an interview on 7/30/24 at 7:08 a.m., Confidential Resident C8 stated, the food is always cold, it doesn't matter what meal it is .the food is cold. During an observation on 7/30/24 at approximately 7:15 a.m., Confidential Residents C10 and C11 were talking to each other at a table in the dining room. C10 stated the food is going to be cold . C11 stated the food is always cold. During an interview on 7/30/24 at 8:16 a.m., Confidential Resident C12 stated the food is warm for the first time ever. During an interview on 7/30/24 at 8:44 a.m., Confidential Resident C13 stated the food is ok, but not that warm. During a confidential group interview on 7/30/24 at 10:30 a.m., 5 (C7, C14, C15, C16, C17) of 12 residents agreed the food is not palatable due to cold temperatures of food. C14 stated, the food in my room is cold . the food in the dining room is cold .I would ask the staff to warm up the food, but I would be asking at every meal . the food is like rubber. C16 stated, the food is cold . everyone in here would say the food is cold but they won't say anything . C7 stated, the food is cold .we don't get toast, it is either burnt or just bread . the eggs are overcooked, cold, and rubbery. C15 stated my food is cold. C17 stated my food is cold. During an interview on 7/31/24 at 10:10 a.m., C15 stated, residents do bring up concerns in resident council . during the meeting there have been complaints about cold food. During an interview on 7/31/24 at 10:12 a.m., C14 stated I have brought up my concerns in resident council . I have definitely brought up my concerns about the temperature of the food . [Certified Dietary Manager (CDM) C] comes down to the meetings and I tell her about the cold food temperatures, eggs, and toast . I have been here about a year, and I have complained to the Nursing Home Administrator about the cold food, and nothing has changed . they wanted me to go to the dining room to eat, why would I do that . I then could sit in the dining room for two hours and wait to eat cold food . now I just eat the cold food in my room During an interview on 7/31/24 at 12:02 p.m., C7 stated, I have told [CDM C] how cold the food is .the food is cold all the time, it is so upsetting. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/31/24 at 12:12 p.m., Certified Dietary Manager C stated, I attend resident council meetings . the residents have complained about the cold temperatures of the food in the resident council meetings. The CDM did not offer any corrective action completed to address these complaints. Review of policy titled, Resident Council, date implemented 8/7/20, read in part . The purpose of the resident council allow residents to . discuss concerns . make recommendations for improvement of resident services provided by the facility . the Nursing Home Administrator (NHA) reviews the minutes to ensure all groups concerns and grievances are investigated. During an interview on 7/31/24 at 12:21 p.m., the NHA stated There was a resident in the past who commented about the food, but I have not heard from anyone. During an interview on 7/31/24 at 5:35 p.m., this surveyor requested a policy regarding serving palatable food and/or a policy regarding dignified dining experience from Dietician B . policies were not provided by facility. 35103 During an interview on 7/30/24 at 9:16 a.m., Confidential Resident C4 was asked about the timeliness of meals, and the palatability/temperature of the food when delivered. C4 stated, It was 9:45 a.m. when I got my breakfast last week one day. The food is cold most times because the meals are usually late. They blame a lot of this stuff on you guys, you know (State Agency]. Food is often cold. Mostly evening meal is cold food . Lunch and dinner is often cold. Every one (of the meals) is the worst. I think it is because it was so delayed in getting to us. Review of Resident Council meeting minutes on 7/30/24 at 3:30 p.m., with meeting dates from December 2023 through July 2024, found all documentation showing there were no complaints documented about any food concerns during that time period, although facility residents and staff had confirmed the food palatability related to being cold was brought up as a concern frequently in resident council. Review of the Grievance binder, received from the Nursing Home Administrator (NHA) on 7/30/24 at 3:40 p. m., revealed only one complaint, dated 5/2/24, that breakfast was served cold. No other grievances were documented for cold food between December 2023 and July 2024. During an interview on 7/31/24 at 8:47 a.m., Confidential Resident C4 said he had requested french toast but by the time it was delivered he had already eaten his meal. When asked if the food was always hot, C4 stated, No. It is not. During an interview on 7/30/24 at 9:12 a.m., Confidential Staff C19 was asked if facility residents complained about the food temperature. C19 stated, .It is often not hot. Resident do complaint about their food being cold. C19 directed this surveyor to Confidential Resident C2, as a Resident who had complained directly to C19 multiple times about cold food. 40330 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 9:34 a.m., CNA I was asked about two confidential residents (C7 and C14) who reported their meals were sometimes received cold, especially at breakfast. CNA I stated, With 120 residents, it's hard to keep up .It would be nice if the little carts [short open plastic wheeled carts with shelves] had doors on them to keep the food warmer. CNA I reported these small open carts held up to six meal trays at the most and did not hold the food temperatures as well as the large metal closed meal tray carts. CNA I confirmed they sometimes heard the residents complaining about the food being cold on their usual hall (B hall) and heard complaints about the eggs not tasting good. CNA I stated, The eggs don't look like when I make them; they don't look good to eat. On 7/31/24 at approximately 12:00 p.m., Surveyors observed the residents in the main dining room had not received their lunch meal. There were 40 residents in the main dining room. On 7/31/24 at 12:13 p.m., this Surveyor observed approximately 40 residents in the main dining room, and only three residents had been served their lunch meal trays. On 7/31/24 at approximately 12:18 p.m., C6 was observed without a lunch tray and stated, I would rather be eating. I would like to have my food by now. On 7/31/24 at 12:19 p.m., C20 was observed without a lunch tray, and said, You can wait for hours [for the meal], and shared it made them feel frustrated. On 7/3124 at 12:23 p.m., C6 was observed without a lunch tray in front of them On 7/31/24 at approximately 12:23 p.m., at least 20 residents had not been served their lunch meal. On 7/31/24 at 12:31 p.m., C7 was observed without their lunch meal. C7 reported they had been waiting a half hour and stated, It is not unusual, and said I need to eat because I am diabetic. They have plenty [staff] to help, and I don't know why it is taking so long. On 7/31/24 at 12:33 p.m. C18 stated, I have been waiting 45 minutes [for their lunch], and explained they could not wait any longer, as they had to go to the bathroom. C18 then left the dining room. On 7/31/24 at 12:33 p.m., this Surveyor observed several staff in the dining room, with some waiting in the serving line for additional trays. The main lunch meal was observed as hamburger with lettuce and tomato, with mashed potatoes and gravy, or tater tots. On 7/31/24 at 12:34 p.m., this Surveyor observed nine residents without a lunch meal tray in the main dining room. On 7/31/24 at approximately 12:36 p.m. C8 was observed being served their lunch meal. C8 stated, I wait a half hour or more .My food is cold. C8 said it made them feel frustrated. C8 declined another entree or tray when asked, as they said they just wanted to eat since they waited so long. . (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/31/24 at 12:36 p.m., the Director of Nursing (DON) was observed in the dining room and was notified C8 reported their hamburger was cold. C8 was heard telling the DON their food was cold and declined another tray or reheating of their lunch meal. On 7/31/24 at approximately 12:38 p.m., C9 was observed being served their lunch meal. C9 stated, I don't think it's ok to wait . It gets me upset, as I don't want to wait a half hour [for their meal]. On 7/31/24 at 12:40 p.m., the last few residents in the dining room were observed receiving their lunch trays. A review of the Be Our Guest document, no date, provided by the facility indicated the meal service was communicated to residents, families and staff as follows: Breakfast beginning at 7:15 a.m., Lunch beginning at 11:50 a.m. and Dinner beginning at 5:00 p.m. daily. Review of the policy, Resident Meal Service, revised 01/01/2022, revealed, Each resident shall receive the correct diet, with preferences accommodated as feasible, and shall receive prompt meal service and appropriate feeding assistance .