STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to obtain an assessment and physician's order for self-administration of medications for one (R98) of one resident reviewed for self-administration of medication/treatments. Findings include: On 1/7/25 at approximately 10:20 AM, R98 was observed lying in bed. The resident was alert and able to answer questions asked. During the interview, several medical ointments/treatments were observed on the resident's shelf and on their tray table next to their bed. Observations included the following: Hydrocortisone 1%, Antibiotic creams, Icy hot and Bio freeze. When asked about the medications, R98 reported that they can put some of them on themselves or staff can put them on as well. On 1/8/25 at approximately 11:50 AM, R98's room was observed. The medications remained in the room on the resident's shelf. At approximately 12:00 PM, Nurse 'D who was assigned to the hall where R98 resided, entered the room with the Surveyor and noted the medications observed should not be in open areas in the resident's room. Nurse D noted that the resident did not have an order to self-administer medications. Nurse D removed the medications from R98's room and brought them to Unit Manager (UM) E. On 1/8/25 at approximately 12:15 PM, UM E was interviewed regarding the facility protocol on self-administration of medications and/or leaving medications unlocked in a resident's room. UM E reported that residents who want to self-administer medications must have an order. In addition, if they do have an order, the medications should be locked up when not in use. UM E noted that R98 did not have an order to self-administer medications. On 1/8/24 at approximately 2:09 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to the facility policy pertaining to self-administration of medication and medication storage, the DON reported that residents must have an order to self-administer medications, and those medications should be locked up when not in use. With respect to R98, the DON noted that they believed the residents significant other was bringing in the medications. A review of R98's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: cerebral infarction, type II diabetes and pain in shoulder and hips.A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 11/15 (moderately cognitively impaired). (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Self-Administration of Medications was reviewed and documented, Policy. In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility .Procedures .For those residents who self-administer, the interdisciplinary team verifies the residents ability to self-administer .if the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted .

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to ensure timely and accurate advanced directives information was in place and ensure resident wishes were timely implemented for two R66 and R2 out of four residents reviewed for Advanced Directives. Findings include: R66 On [DATE] at approximately 10:30 AM, R66 was observed lying in bed. The resident was alert, but not able to answer any questions asked. A review of R66's clinical record noted the resident was initially admitted to the facility on [DATE] with diagnoses that included: dementia, chronic kidney disease and anxiety. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was severely cognitively impaired. The top of the resident's electronic face sheet indicated the resident was a FULL CODE. Continued review of R66's clinical record noted a form titled, Advance Directives/Medical Treatment Decisions ([DATE]) that documented: This is to acknowledge that I have been informed in writing in a language that I understand of my right and all rules and regulations to make decisions concerning medical care, including the right to issue Advance Directives to be followed should I become incapacitated .I have chosen to formulate and issue the following Advance Directives .Do Not Resuscitate(DNR) (an X was checked in the box). The form was signed by the resident and another signature noted as Legal Representative on [DATE]. On [DATE] at approximately 9:17 AM, an interview was conducted with Social Worker (SW) G. SW G was asked as to the facility protocol regarding Advanced Directives/Code Status. SW G noted that when residents enter the facility, they receive admission paperwork and are asked to determine if they want to be FULL CODE or DNR. They are also asked to provide or complete Advanced Directive Forms. When asked about R66's record that noted the resident was a FULL CODE but had a form completed that noted their wish was DNR, SW G reported that there appeared to be a discrepancy between the two that needed to be corrected. On [DATE] at approximately 10:48 AM, an interview was conducted with Social Worker (SW) F. SW F reported that they were assigned to R66. SW F was asked why R66's wishes to be a DNR was not properly entered in the resident's clinical record. SW F noted that the form Advance Directives/Medical Treatment Decisions completed by the resident and resident's family was not considered effective until a physician discussed the wishes with the resident and/or the resident's responsible party. SW F also reported that they recall talking with the resident who decided they wanted FULL CODE. They further reported that there were notes in the resident's record that indicated they changed their wishes to remain FULL CODE. SW F was asked to provide supporting documents. *It should be noted that no documents indicating the resident's choice to be FULL CODE was provided prior to the end of the survey. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of R66's clinical record was conducted. An attempt to locate SW F's notes regarding the R66's wishes was made. No notes were found. However, a hospital record dated [DATE] documented, in part: I discussed CODE STATUS .patient did not want CPR or intubation .Will continue as DO NOT RESUSCITATE . A Durable Power of Attorney (DPOA)for Health Form (dated [DATE]) was located in the resident's record. A second interview was conducted with SW F. SW F was asked if the resident had been deemed incompetent. SW F reported that they had been but noted the document needed to be placed in the resident's record. SW F was then asked if there had been any discussion with the DPOA (Durable Power Of Attorney) or family member. SW F reported that they had not talked with the family member. R2 On [DATE] at approximately 9:20 AM, R2 was observed lying in bed. The resident was alert and able to answer most questions asked. During the interview the resident reported that they were not happy at the facility and wished they could return to their prior home. A review of R2's clinical record noted the resident was initially admitted to the facility on [DATE] with diagnoses that include: paranoid schizophrenia, post-traumatic stress disorder, and type II diabetes. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] (cognitively intact cognition). The resident was noted as a FULL CODE. Continued review of R2's clinical record revealed, in part, the following: [DATE] -Social Services: .Resident's son is activated DPOA as her DPOA paperwork is activated as her DPOA paperwork is not dependent on her ability to make decisions . A document titled; General Durable Power of Attorney was reviewed. The form documented in part: I R2 .appoint my son (name redacted) as my Agent with full power, unless I direct otherwise, to conduct all of my affairs .My Agent is authorized .with respect to any of my property and interests in property as follows .Manage assets .Debts .Deposits .Checks . Borrowing .Collection [NAME] .Securities and investments .Litigation .Insurance .Taxes .Services .Support . Benefits .Vehicles .Powers related .POWERS RELATED TO MY PERSONAL CARE Establish residency . Care contracts .Medical and personal records . *It should be noted the form did not authorize R2's son to make decisions as to code status, medication/treatments etc. Further there were no notes located in the resident's record that indicated discussion were made regarding R2's wishes. Consent forms for the following medications were signed by the R2's son: Xanax ([DATE]), Trazadone ([DATE]), Lexapro ([DATE]). [DATE]: Infection Control Information Consent Forms: No was checked for: Influenza (Flu), Pneumonia, COVID booster, Shingrix (Shingles), Respiratory Syncytial Virus (RSV) the form was signed by R2's son. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 4:55 PM, an interview was conducted with SW F. SW F was asked if R2 had been deemed incompetent. They reported that they had not. When asked why R2's son was making medical decisions for the resident and if end of life wishes had been discussed with R2. SW F noted that R2 had an unusual DPOA that indicated the resident did not have to be deemed incompetent to allow their son to make health care decisions. The DPOA document was reviewed with SW F and a discussion as to the limitations on medical treatment/end of life decisions was discussed. On [DATE] at approximately 9:06 AM, a discussion about R66 and R2 lack of proper DPOA documents was conducted. The Administrator noted the discrepancies. The facility policy titled, Advance Directives/Advance Care Planning was reviewed and documented, in part: Policy Statement: Advance directives will be respected in accordance with state law and facility policy .Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance if he or she chooses to do so .prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directives . information about whether or not the resident has executed an advance directive shall be displayed promptly in the medical record .The Attending Physician will provide information to the resident and legal representative regarding the resident's health status, treatment options .Durable Power of Attorney for Health Care .a document delegating authority to a legal representative to make health decisions in case the individual delegating that authority subsequently become incapacitated .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure a clean, comfortable, homelike environment for for five residents, (R#'s 105, 46, 16, 17, 58, 84, and 30) of five residents reviewed for a homelike environment, and for 11 residents (who wished to remain anonymous) from the group meeting, resulting in verbalized complaints regarding the environment, housekeeping, and laundry services. Findings include: On 1/7/25 at 9:40 AM, the tube feeding pole in room [ROOM NUMBER] was observed to have dried up tube feeding formula staining the length of the pole and on the braces holding the wheels. On 1/7/25 at 9:55 AM the wall behind R16's bed was observed with a large area of missing paint and numerous long and deep gouges in the drywall. On 1/7/25 at 10:05 AM, room [ROOM NUMBER]-W (bed at the window side of room) was observed to have dirty clothing, crumbs, empty food and beverage packaging, food and paper debris, and empty pistachio shells strewn about the floor. It was further observed a large, five pound tub of raw honey with sticky, soiled debris on the jar and lid of the jar. On 1/7/25 at 10:28 AM an interview with R105 was conducted regarding housekeeping and said sometimes they services was okay and sometimes it wasn't. They said often times the floors needed to be swept and mopped and it didn't get done. On 1/7/25 at 10:31 AM, R46's floor very soiled with what appeared to be sticky food substances on the left side of the bed. R46 said the facility frequently provided no housekeeping services on the weekends. They were asked the last time the floor had been swept and mopped and said it had been a few days. On 1/7/25 at 10:36 AM, R58's room was observed to have three open translucent garbage bags on the floor. Two bags were observed to contain linens (unclear if clean or dirty), and one bag appeared to have trash contained in it. On 1/7/25 at 10:40 AM, R17 was observed up in their wheelchair. There were no linens on the bed and multiple towels and a gown were observed to be tossed under the bed. On 1/7/25 at 11:07 AM, R84 said the facility had a difficult time providing clean linens on the nights and weekends. They further reported there were no housekeeping staff on the weekends. On 1/8/25 at 2:29 PM, and 1/9/24 at 8:16 AM, room [ROOM NUMBER]'s bathroom was observed to contain a bedside commode with multiple articles of clothing not stored in a bag piled on top of it. On 1/9/24 at 8:10 AM, room [ROOM NUMBER]'s floor was observed to be littered with paper and food/crumb debris. The bathroom floor had a black sticky substance with crumbs and paper debris sticking to the floor. In the corner of the bathroom an open translucent garbage bag was observed on the floor with clothing spilling from the top of the bag. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/24 at 8:14 AM, room [ROOM NUMBER]'s bathroom floor was observed with four open translucent trash bags containing a mix of clothing and linens. On 1/9/24 at 8:16 AM, room [ROOM NUMBER]'s bathroom was observed with wadded up clothing not contained in a bag piled in the seat of a wheelchair. Resident Council On 1/8/25 at 11:00 AM, a Resident Council meeting was conducted with 11 residents who requested to remain anonymous. During the meeting, the residents who were cognitively intact, were asked questions regarding care and life at the facility. The residents expressed numerous concerns about the facility's failure to keep a clean, comfortable and homelike environment. One resident noted that they had concerns regarding linen and towels. The resident noted there have been times when their linen is wet, and they ask staff to change it. Staff will tell them that they do not have any and will place several towels over the wet linen. Another resident reported the same concerns. They noted that they believe that some of the staff hoard linen and makes it difficult for other staff to find proper linen. Another resident noted that staff often try to obtain linen but often do not have keys to unlock them from storage. Further concerns centered around ensuring housekeeping was routinely done. One resident reported that housekeeping was very limited over the weekends and often their room was not properly cleaned. Another resident noted that often housekeeping is not timely picking up garbage off the floor, leaving pill cups on their bedside tables and leaving dirty used tissues in residents' rooms. A third concern centered around laundry. The residents reported that in the past the facility left bins in the residents' bathrooms. Dirty laundry would be placed in the bins and staff would pick up laundry from the bins and they believed that system worked best. Another resident stated that in October 2024 the facility changed the way dirty clothes were taken down to the laundry room They noted that staff now pick up dirty laundry, put them in plastic bags and then it is sent to laundry. One resident explained that they did not believe the bags are labeled with their names or room number and they often do not get their clothes back. Another resident had a concern that staff often mixed dirty linen with dirty clothes and they thought that was an infection control concern. A third resident stated that there was only one person who was doing laundry and that made things difficult to get their clean laundry back timely. R30 On 1/7/25 at approximately 10:30 AM, R30 was observed sitting in their room. The resident was alert but had difficulty answering all questions asked. A piece of paper was observed on the closet door that noted their family was responsible for doing the resident's laundry. A review of R30's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included type II diabetes, Encephalopathy and dementia. The resident's daughter was noted to be their active DPOA (durable power of attorney). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at approximately 12:51 PM a phone interview was conducted with the resident's DPOA. They reported that many times the resident's clothes go missing and they believe staff is sending their clothes to the laundry. On 1/7/25 at approximately 1:45 PM, Laundry Staff (LS) I was observed returning laundry to R30's room. When asked why they were bringing back clothes as there was a note in the resident's room that indicated the resident's family was to do their laundry, LS I stated that things have been very difficult for them and other staff since the facility changed the way laundry was to be removed form residents' rooms. On 1/9/25 at approximately 9:03 AM, an interview was conducted with the Administrator. The concerns brought up at the Resident Council meeting and concerns pertaining to R30 were discussed. The Administrator reported that they were aware of the concerns regarding linen and noted that staff had been educated to not hoard linen. They also noted that change in laundry was done with an effort to try to get clothes back to residents timely. 34275 38271 On 01/07/25 at approximately 9:52 a.m., During the environmental rounds, a review of the facility was conducted with Maintenance Director R (MD R) and the following was observed: At approximately 10:03 a.m., room [ROOM NUMBER] had a nebulizer respiratory machine plugged into an standard extension cord. MD R was queried regarding the medical device being plugged into the extension cord and they reported that was not allowed and that the nebulizer should be plugged into an outlet. At approximately 10:15 a.m., room [ROOM NUMBER]-D had large gouges in the wall of their room consisting of approximately three feet up and down. MD R was queried regarding the gouges and reported that they had not been made aware of them. MD R was asked what the process was for notifying maintenance staff for needed repairs and they indicated the facility has a reporting system called TELS (a system used to communicate work order with maintenance) that staff can use to create a work order that notify's maintenance of needed repairs. MD R was asked if any work orders were in TELS for the drywall repair and they indicated that none were made. At approximately 3:03 p.m., an inspection of the facility laundry room was conducted and the following was observed: Collected-layered dust was observed behind the washing machines and the Clean linen racks were observed in the dirty washing section with the flaps up exposing the clean linens to potential contaminants in the room. A facility document titled Quality of life: Homelike Environment was reviewed and revealed the following: Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure medication were administered and documented per professional standards for two residents, (R#'s 47 and 104) of five residents reviewed for professional standards with medication administration and documentation resulting in verbalized complaints of not receiving as needed pain medications on time and inaccurate medical record keeping. Findings include: R47 On 1/7/25 at 10:47 AM, an interview was conducted with R47. They said they did not believe the nursing staff were accurately recording the times they received their as needed narcotic pain medication resulting in them experiencing a delay of receiving their next as needed doses. On 1/8/25 at 2:23 PM, a review of R47's clinical record revealed they admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: heart failure, diabetes, and chronic kidney disease. R47's most recently completed Minimum Data Set assessment revealed R47 had intact cognition. A review of R47's physician's orders was conducted and revealed an order for oxycodone 5 milligrams, give two tablets every six hours as needed. A review of R47's CONTROLLED SUBSTANCE RECORD (a form used to document the proof of use and reconciliation of controlled substances) and Medication Administration Record (MAR) was conducted and revealed the following: oxycodone signed out on the CONTROLLED SUBSTANCE RECORD on 1/3/25 by Nurse 'A' at 9AM, no documentation on the MAR the medication had been given. oxycodone signed out on the CONTROLLED SUBSTANCE RECORD on 1/5/25 by Nurse 'J' at 5:30 AM, no documentation on the MAR the medication had been given. oxycodone signed out on the CONTROLLED SUBSTANCE RECORD on 1/5/25 by Nurse 'A' at 1 PM, no documentation on the MAR the medication had been given. oxycodone signed out on the CONTROLLED SUBSTANCE RECORD on 1/5/25 by Nurse 'A' at 7 PM, no documentation on the MAR the medication had been given. oxycodone signed out on the CONTROLLED SUBSTANCE RECORD on 1/6/25 by Nurse 'K' at 6:10 PM, no documentation on the MAR the medication had been given. On 1/8/25 at 1:20 PM, an interview was conducted with Nurse 'A' regarding administration and documentation of R47's oxycodone. They were asked why they did not document the administrations of the medications on the MAR and offered no response, only saying it was, habit to check the CONTROLLED SUBSTANCE RECORDS for the timing and administration of the medication. On 1/8/24 at 1:58 PM, an interview was conducted with the facility's Director of Nursing regarding the documentation of medications on the MAR and said all medications given should be documented at the time they were given on the MAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility provided policy titled, Medication Administration was conducted and read, Medications are administered in a safe and timely manner, and as prescribed .23. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug . 49083 Resident 104 Clinical record review revealed R104 was admitted to the facility on [DATE] with medical diagnoses including hypertension, heart failure, prostate cancer, thyroid disorder, and renal Insufficiency. A Brief Interview of Mental status (BIMS) score 15/15 indicating R104 was cognitively intact. On 1/8/25, at 10:34 AM, Licensed Practical Nurse (LPN) A was observed administering medications to R104. On 1/8/25 at 11:50 AM, A medication reconciliation record review was attempted of the Medication Administration Record (MAR) and revealed no medications that were observed administered to R104 were documented as given. On 1/8/25 at 1:37 PM, A medication reconciliation record review was attempted of the MAR and revealed no medications that were observed administered to R104 were documented as given. On 1/8/25 at 2:09 PM, A medication reconciliation record review was attempted of the MAR and revealed no medications that were observed for medication administration were documented as given to R104. The Director of Nursing (DON) was informed the medication administration survey could not be completed because LPN A had not documented administration of R104's medications from the morning observation. When questioned when Nursing is to document medication administration, the DON confirmed Nursing documents medications given at the time they are administered. Review of the facilities policy titled; Medication Administration dated 4/2019 documented: .The individual administering the medication initials the resident's EMAR <sic> after giving each medication .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to assess a resident for alternative or augmentative communication methods to ensure functional communication for one Resident (R91) of one resident reviewed for activities of daily living. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 9/26/24, revealed R91 was admitted to the facility on [DATE], with diagnoses including stroke, aphasia (difficulty speaking), hemiplegia or hemiparesis (paralyzed or weak limbs), seizure disorder, and depression. The sensory assessment revealed R91 had adequate hearing and vision, was non-verbal, and showed they could rarely communicate their needs. The Brief Interview for Mental Status (BIMS) assessment revealed R91 could not participate. The activities of daily living assessment showed R91 could eat independently without set-up. On 1/07/25 at 12:10 p.m., R91 was observed in their bed eating their lunch. R91 pointed angrily at their meal card ticket with their left hand and held it up for the Surveyor to see. R91 next pointed to their plate of food, and then to their mouth and shook their head 'no'. R91 then picked up his small juice drinks and shook his head 'no'. R91 appeared distressed with their face frowning and furrowing of their eyebrows. R91 then pointed to their mouth and opened it. Surveyor observed a small sore on the top of R91's upper mouth, with no obvious teeth. R91 was asked if they had pain and nodded 'yes'. Surveyor was unable to understand what R91 did not like about their food. Surveyor next asked yes and no questions and by a process of elimination learned R91 did not like their modified diet of soft food and thickened liquids and wanted regular food. Surveyor asked R91 if they could write. R91 shook their head 'no' and showed Surveyor their right hand, which was tightly clenched in a fist. When asked if they were right-handed, R91 shook their head, 'yes'. There was no rolled washcloth, palm protector, or splint in their hand. R91 continued to point at their right hand. When asked if they wanted something to open their hand, R91 nodded 'yes'. R91 then pointed to their right foot, which was directly on their mattress, pointed down, and to their closet. A foot brace was observed and R91 pointed to the brace, an ankle foot orthosis, and then pointed to their right foot. R91 was asked if they wanted the brace on their foot, and R91 nodded 'yes'. Surveyor let R91 know they would follow up with staff. On 1/07/25 at approximately 12:15 p.m., R91 appeared distressed during the interview with difficulty communicating their needs and nodded 'yes' they felt frustrated with their communication. R91 then gestured again to Surveyor and Surveyor was unable to understand what they were trying to say. R91 was asked if they wanted a way to better communicate their needs and nodded 'yes'. When asked how this made them feel, R91 showed surveyor a sad face, by showing tears below their eyes and squinting their eyes. Surveyor looked for an augmentative or alternate communication device or a communication board in R91's room to assist them to express their needs and none was found. R91 was asked if they had any device to assist with communication, they shook their head, No. On 1/07/25 at 12:18 p.m., review of R91's meal ticket showed they were on a mechanical soft, thickened liquid diet. (continued on next page)

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Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/07/25 at approximately 12:20 p.m., R91's aide, Certified Nursing Assistant (CNA) L, was asked how they communicated with R91 and if there was any assistive devices or alternate means of communication, given R91's extensive efforts, extra time, and expressed frustration communicating their needs. CNA L reported there was no communication board and R91 could not write. When asked how they communicated with R91, CNA L responded R91 pointed at objects in their room to communicate some of their needs, although they could not communicate all their needs this way. When asked about R91's concerns, CNA L reported the staff were working on R91's teeth and dentures, and confirmed R91 did not like their soft modified diet, and they had no hand splint, or treatment for their right hand. On 1/07/25 at approximately 12:25 p.m., the Unit Manager, Registered Nurse F, was asked how R91 communicated with staff. RN F reported they communicated by pointing to show what they needed. Surveyor asked RN F if they had any assistive, alternate, or augmentative communication devices to express all their needs. RN F responded, No. RN F was notified about R91 pointing to their mouth and reporting pain, and how they pointed to their right hand being closed and pointed to their meal ticket and expressed being frustrated with their diet. RN F reported would they follow up. RN F reported R91 could read when asked if they could read their meal ticket, since R91 showed it to Surveyor. Surveyor shared R91 reported feeling sad. Review of R91's nursing progress note, dated 1/07/25 at 1:59 p.m., confirmed R91 communication with nursing staff showed they did not want their mechanical soft diet, and complained of pain in their hand and mouth pain. The note also showed R91 was sad and depressed. This confirmed Surveyor communication with R91 and showed potential for improved communication with augmentative communication, sign language (left hand) or other mediums of functional communication. On 1/08/25 at 9:18 a.m., CNA M was asked about R91's communication, and stated R91 should have a communication board in their room, since they did a lot of pointing for their basic needs but wanted to communicate more than they could do by pointing. CNA M reported R91 could point when they needed to use the urinal and could read their activities and their chronicle (newsletter) daily. CNA M stated, We try to guess (at their gestures) and see if we can be accurate .I think speech therapy should work more on (their) speech, as it's not all coming out (their needs). CNA M reported they had not referred R91 to speech therapy. CNA M saw R91 did not have a communication board in their room, and said they would get them one from the facility social worker, who supplied them. On 1/08/25 at 10:11 a.m., the Director of Rehabilitation, Certified Occupational Therapist Assistant (COTA) N, confirmed the social workers in the facility distributed the communication boards. COTA N was asked if speech therapy was addressing communication and facility communication boards, as they had evaluated R91 on 1/07/25 and had only addressed their swallowing. COTA N planned to clarify this. Surveyor requested R91's speech therapy records. Review of R91's speech therapy records confirmed speech therapy had seen R91 for dysphagia only on 1/07/25, not for communication. Communication was added to a revised 1/08/25 speech therapy assessment, with the diagnosis of aphasia (difficulty speaking), dated 1/08/25. Further record review revealed R91 was seen for speech therapy for another episode beginning 5/29/2024, for dysphagia only. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R91's Care Plan revealed, Difficulty communicating as evidenced by (R91 was) nonverbal related to aphasia. Able to communicate by using hand gestures and nods head for 'no' and 'yes' answers. Able to follow commands. Date initiated: 11/15/2022. Revision on 3/30/2024 . There were no alternate types of functional communication systems noted, such as communication boards, tablets, computers, sign language or otherwise, given R91 was observed and staff reported they could point for some but not all of their needs. Review of R91's therapy notes requested from the facility revealed speech therapy records only, and no occupational or physical therapy records, which COTA N confirmed. Review of R91's updated speech therapy evaluation, dated 1/08/25 at 3:15 p.m., revealed R91 was evaluated for dysphagia and swallowing therapy on 1/07/25 and on 1/08/24 for functional communication (at 1:54 p.m.), after discussing R91's functional communication with COTA N. On 1/08/25 at 12:04 p.m., Registered Dietician, RD Q, confirmed R91 was unhappy with their modified texture diet after meeting with them. RD Q shared R91 was holding up their beverages cups in the air and slamming them down. RD Q reported they were able to understand R91's likes and dislikes from yes and no questions, showing R91's potential to communicate their needs. Review of R91's activity note, dated 12/23/24, revealed R91 was alert and oriented times 2-3 spheres, was able to make some (not all) of their needs known by nod/shaking their head or gestures. On 1/09/25 at approximately 9:25 a.m., COTA N accompanied Surveyor to R91's room where a laminated, four-page communication board was observed on R91's bulletin board in their room, out of reach. Each page had anywhere from 14 to 20 pictures to communicate both basic and more specific needs, including pain, medications, washing hair, and thirsty and some items which did not relate to R91's care, including suctioning, crutches, intravenous feeding, and oxygen. R91 held the pages up with their left hand and squinted with one eye, held the board up to one side, and pointed at the pictures. R91 was successfully able to point to the pain and the medication pictures, and then pointed to their head. COTA N asked R91 if they wanted pain medication and they nodded 'yes'. R91 then pointed to the shoe picture and their brace in their room and showed COTA N they wanted their foot brace on. COTA N stated they would ask speech therapy to provide a communication board with less boxes, since they had evaluated R91 for use of a more basic communication board on 1/08/25. When COTA N went to reattach the communication board back onto R91's bulletin board in their room on their right (impaired side), R91 waived their arms no and pointed to their bedside table on their left side. COTA N placed the laminated communication board pages on their bedside table, per R91's wishes. R91 pointed to the picture of dentures (mouth) and then picked up their juice cups and slammed them on the bedside table. When asked, R91 showed they did not want them and appeared agitated. Review of R91's Speech therapy evaluation, updated to include functional communication on 1/08/25, showed speech therapy services evaluated and planned to provide training in augmentative communication with a communication board to R91. This showed some functional potential for R91 to use adaptive and or augmentative communication, given this goal by the evaluating speech therapist. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the speech therapy evaluation showed for reading comprehension, R91 was able to comprehend basic sight words or phrases in everyday context 26-49% of the time, participate in communication exchanges without additional assistance 26-49% of the time, participate in multi-modality communication (different modes of communication) to convey simple meaningful messages related to routine daily activities in low-demand situations 26-49% of the time, and participate in short, structured meaningful conversations in low-demand situations 26 to 49% of the time. The assessment showed R91 demonstrated the rehabilitation potential to communicate functionally, and speech therapy would be exploring various alternate means of communication, including the use of a communication board, and other communication training, strategies, and mediums. On 1/09/25 at 12:43 p.m., the Activity Director, Staff H, was asked about R91's communication and reading ability during activities. Staff H confirmed R91 received the daily new chronicles and they believed they could likely read it, or at least some of the pictures. Regarding yes/no questions, Staff H reported R91 seemed to be accurate in their responses, and they could follow one-step directions. On 1/09/25 at approximately 2:00 p.m., the concerns related to R91's functional communication were shared with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The DON expressed they believed R91 pointing at objects in their room was functional communication, and the NHA had no additional comment. A policy titled, Assistive Devices and Equipment was received, however did not address functional communication or adaptive or augmentative communication devices. The facility was asked for a resident communication policy; none was provided by the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure Hospice services were provided per plan of care for one resident, (R4) of one resident reviewed for Hospice, resulting in R4 not receiving Hospice services per the provisions. Findings include: On 1/7/25 at 10:25 AM and 1:05 PM, R4 was observed in their bed asleep. On 1/8/25 at 11:25 AM, a review of of R4's clinical record revealed they admitted to the facility on [DATE], and most recently readmitted on [DATE] with diagnoses that included: multiple sclerosis, pressure ulcers, osteomyelitis (bone infection, anxiety disorder, dementia, and contractures. R4's most recent Minimum Data Set assessment revealed R4 had moderately impaired cognition and required assistance from staff for activities of daily living. On 1/7/25 at 12:54 PM, continued review of R4's record revealed they signed on for Hospice services on 10/14/24. A review of the Hospice plan of care and orders for the benefit period of 10/14/24 thru 1/11/25 was conducted and indicated R4 was to receive skilled nursing visits twice a week and as needed, and nurse aide visits twice a week and as needed. A review of hospice staff notes revealed their first skilled nursing visit occurred on 10/30/24, two weeks after they signed on for services. Continued review of the notes revealed skilled nursing visits on the following dates: 11/5/24, 11/14/24, 11/20/24, 11/26/24, 12/12/24, 12/13/24, 12/19/24, 12/27/24, and 1/2/25. It was noted the skilled nursing progress notes did not indicate R2 receive the the plan of care skilled nursing visits twice per week. It was further discovered R2 had no documented visits from a Hospice nurse aide. On 1/8/25 at 11:08 AM, an interview was conducted with the facility's Director of Nursing (DON) they were asked who in the facility followed up to ensure the Hospice company was conducting visits per their plan of care and said they did not know if anyone followed up to ensure Hospice staff were completing the visits. They were then asked about the particular Hospice company R4 had signed up with and said they thought R4 was to receive skilled nursing visits one time per week and nurse aide visits twice per week. At that time R4's Hospice plan of care was brought to their attention with the outlined provisions of visits from the nurse and aide being scheduled twice per week. They indicated they would follow-up with the Hospice company for clarification. At 11:21 PM, the DON followed-up and agreed the services had not been provided per plan of care. A review of a facility provided policy titled, Hospice Program was conducted and read, .5. Hospice providers who contract with this facility: a. must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency; and b. are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility .12. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review the facility failed to ensure an order for supplemental oxygen for one resident (R17) of one resident reviewed for oxygen. Findings include: On 1/7/25 at 10:40 AM, R17 was observed up in their wheelchair. An oxygen concentrator powered on was observed at the the bedside with the nasal cannula tubing draped over the top of the concentrator. It was observed the concentrator delivery rate was set at two liters. An interview was attempted, however; R17 was did not respond to attempts at verbal communication. During the observation, staff were observed to enter the room and place the nasal cannula delivering oxygen on R17. On 1/7/24 at approximately 12:50 PM and 2:35 PM, R17 was observed up in their wheelchair at the bedside with two liters of oxygen being delivered via nasal cannula from the concentrator. On 1/8/25 at 9:00 AM, 11:04 AM and 1:06 PM, R17 was observed in their bed with two Liters of oxygen being delivered via nasal cannula from the concentrator. On 1/8/25 at 2:18 PM, a review of R17's clinical record revealed they admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: spastic hemiplegic cerebral palsy, adjustment disorder, dysphagia, high blood pressure, and chronic pain. A review of R17's physician's orders was conducted and did not reveal an order for supplemental oxygen On 1/8/25 at 1:58 PM, an interview was conducted with the facility's Director of Nursing and it was indicated there should have been an order for supplemental oxygen. A review of a facility provided policy titled, Oxygen Administration was conducted and read, The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on interview and record review, the facility failed to provide appropriate interventions to prevent triggers for one Resident (R8) of one resident reviewed for trauma-informed care and Post Traumatic Stress Disorder (PTSD). Findings include: Review of R8's Minimum Data Set (MDS) assessment, dated 9/27/24, revealed R8 was admitted to the facility on [DATE], with current diagnoses including heart failure, depression, anxiety, and PTSD (Post Traumatic Stress Disorder). R8 had no physical, verbal, or other behaviors towards others. R8 required supervision or touching assistance with bed mobility and transfers, and minimal assistance for toileting. The depression assessment (PHQ-9) showed a score of 19/27, which revealed moderately severe depression. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, showing R8 was cognitively intact. On 1/08/25 at 11:24 a.m., R8 was observed in their bariatric hospital bed. R8 reported they were struggling to adjust to being a long-term care resident at the facility, given their younger age, but understood they needed significant care. R8 shared they had a diagnosis of PTSD, however, did not share their triggers or what would help, and was not asked. R8 reported they did not like their current psychological provider and this was why they refused the visits, as the provider reflected what they said back to them and did not offer strategies or solutions for their adjustment concerns. R8 shared they had told social services and nursing staff they wanted another care provider, or for the social worker to assist them, but nothing had changed. R8 stated they still wanted additional social services support in house, and another care outside psych care provider. Review of R8's facility diagnosis list in the Electronic Medical Record (EMR) revealed a diagnosis of PTSD, dated 8/29/24. Review of R8's physician orders revealed they were prescribed a medication for PTSD, Prazosin, on 8/29/24, and remained on this medication as of 1/09/25. Review of R8's physician provider notes revealed they were diagnosed with PTSD, Chronic, and were noted as taking Prazosin for PTSD during January 2025 (noted on 1/03/25), December, 2024, November, 2024, October, 2024, and August, 2024 (initiated 8/28/24). Review of R8's Care Plan, accessed 1/08/25, revealed no Care Plan for trauma-informed care (PTSD), trauma, or for triggers for their PTSD diagnosis. Further review of R8's Insomnia (lack of sleeping well) Care Plan, accessed 1/08/25, dated 10/01/24, revealed a diagnosis of insomnia due to medical condition, PTSD, anxiety, and depression, with interventions, Establish a HS (nighttime) routine with Resident (80), maintain consistent schedule with daily routine, and monitor for factors that may contribute to poor sleeping. There was no mention of any trauma triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R8's Behavioral Care Plan, accessed 1/08/25, revealed, At Risk for behavioral symptoms r/t (related to) agitation and hallucinations . This included Complaints regarding room and facility but chooses not to move rooms or have referrals made to other facilities, accusations, calling 911 reporting (they) just wanted someone to come to (their) room, yelling out, making accusatory statements r/t staff not providing care and nobody assisting ADLs (activities of daily living care needs), while multiple staff in (their) room, . falsifying health conditions and exacerbating symptoms, appears fine before staff walks into room; when staff walk into room (R8) states (they) can't breathe, shaking, calls 911 (emergency services number) despite physician recommending (they) go to hospital. Date initiated 2/28/22. Revision on 12/03/24 . PTSD was not noted on the behavioral care plan, or any triggers identified. Review of R8's Treatment Care Plan, accessed 1/08/24, revealed R8 was non-compliant with care and treatments which included declining medications, declining showers, declining nail care, choosing not to move rooms, declining meals, declining supplements, declining use of light, declining to get out of bed, not wanting to be changed when soiled, declining diet downgrade, declining to see dentist, taking off their oxygen, declining therapy evaluations and sessions, declining to get back in bed when asking to be put back, declining to have a wound picture taken, declining to go to scheduled appointments, and declining leg ACE wraps. PTSD was not noted on this Care Plan, or any triggers. Review of R8's psych progress note, dated 8/14/24, revealed, (R8) shared with this social worker that it's hard to accept that (they) will be living in a nursing home for the rest of (their) life . There was no documented follow-up regarding this concern. Review of R8's psychiatry assessment provider note, dated 8/16/24, revealed R8 reported night terrors and only being able to sleep 10 to 20 minutes at time. R8 reported during the assessment they had observed verbal abuse towards a family member and had to take on a role of trying to save their other family member. Review of R8's psych progress note, dated 8/27/24, revealed, (R8) is complaining of Terrible night terrors. (They) said, I try to avoid going to sleep because they are so bad . Review of R8's psychiatry progress note, dated 8/28/24, revealed their night terrors were so bad, they were trying to avoid going to sleep. The note stated, (R8) talks about her 'night terror' and reports being r/t (related to) h/o (history of) trauma, with their (family member) and watching them abuse (family member) in addition to dealing with emotional and verbal abuse (themselves) . Their diagnoses on this report included major depressive disorder, generalized anxiety disorder, and Post Traumatic Stress Disorder (PTSD), chronic. There is a notation in parentheses which said rule out. The report further revealed, Plan: r/t h/o verbal and emotional abuse by (family member) and nightmares. Start Prazosin (a medication for PTSD and nightmares). The report confirmed R8 was a recipient of repetitive traumatic experiences in their family, and the provider deemed medication was needed to address the concerns. Review of R8's psych progress note, dated 9/12/24, revealed R8 reported they were continuing to struggle with their past family trauma, and they were having nightmares. Review of the EMR showed R8 declined five psychological provider visits on: 10/02/24, 10/10/24,10/23/24, 12/04/24, and 12/11/24, with none since 12/11/24. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R8's EMR showed they refused their medications on 1/09/25, they refused their soup (which was their preference) on 1/08/25, showing care refusals in the past week. Review of R8's updated Care Plan, accessed 1/09/25 (date of survey exit), revealed, Post Trauma Symptoms as evidenced by resident report R/T (related to) distressing event outside the range of usual human experience. Will demonstrate ability to deal with emotional reactions as evidenced by verbalization of feelings of adjustment to LTC (Long Term Care Facility) setting, comorbidities. Date initiated 1/09/25 . Interventions included identifying coping strategies, talking about at own pace, providing reassurance of safety, and psychology follow-up as needed. No triggers were identified at that time. Review of R8's Social Services notes and assessments in the EMR (reviewed from 8/28/24 through 1/08/25) showed there were no supportive visits provided to address R8's PTSD/trauma, triggers, or interventions. Social Services did not address R8's many behavioral and care rejection concerns, given their refusals to participate with outside psychological services providers and ongoing signs and symptoms of psychosocial distress, behaviors, and adjustment concerns. On 1/08/25 at 1:04 p.m., Social Worker (SW) F was asked about R8's PTSD diagnosis and reviewed the EMR with Surveyor. Surveyor showed SW F their diagnosis list included a diagnosis of PTSD, and the MDS triggered for a PTSD diagnosis. SW F reported they did not know R8 had a PTSD diagnosis. SW F was asked if they had provided any supportive visits to R8 related to their depression and behaviors and responded they had not. SW F acknowledged they were R8's social worker, and this was within their scope of practice to provide supportive visits, and acknowledged after review of R8's Care Plan and documentation they should have provided supportive visits, given R8's provider refusals and their ongoing behaviors and reported distress. SW F acknowledged there was no formal trauma assessment for R8, however trauma was reflected in their assessments, and had been marked No for 12/2024. SW F acknowledged the PTSD diagnosis should have been on R8's Care Plan separately, and stated, We have no way to know triggers and interventions. I am going to see (R8) and see if (they) will accept supportive visits from myself, and if (they) want to try psychology again, and I will update the Care Plan . SW F reported R8 did better working with females (providers and staff) but did not disclose why. On 1/08/25 at 10:20 a.m., the Rehabilitation Director, Certified Occupational Therapist (COTA) N, confirmed R8 was not participating in therapy services in the facility. COTA N reported they would evaluate R8, who would say they would participate, and then there were many refusals. COTA N did not know why they refused so often. Review of R8's Social Services (SS) Assessment, dated 9/27/24, revealed they had a history of trauma, which manifested in nightmares and feelings of guilt, with no triggers identified. (continued on next page)

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/09/25 at 12:11 p.m., Social Worker (SW) G (the other facility social worker) was asked about R8's Care Plan not designating a trauma or PTSD Care Plan, with triggers identified, given the 9/27/24 SS assessment and notation of trauma and identified concerns. Surveyor reviewed there was no progress note regarding a social services follow-up visit, and no SS supportive visits when R8 declined the outside providers. SW G reviewed the EMR and reported they understood the concerns. SW G reported the process when a resident had a PTSD diagnosis was they would ask them about trauma, complete a PTSD Care Plan, and identify triggers and respective interventions. SW G stated they would then provide supportive Social Services visits. SW G reviewed the 9/27/24 SS assessment, which showed a score of 2 concerns identified. SW F reported they would do a separate trauma assessment with a score of 3 concerns of more. Given R8 reported during the assessment they had nightmares and feelings of guilt about past family trauma, SW G was asked if a separate trauma assessment would have been appropriate. SW G declined to respond. On 1/09/25 at 12:48 p.m., Activity Director (AD) H was asked about R8's participation in facility activities. AD H reported R8 would show an interest in their programs and activities, and then would refuse to participate. AD H explained R8 would say, I want to come to the program; let me know when they are going on, and then would refuse to come. Surveyor asked if R8 had a problem sitting up in their wheelchair and confirmed they had never observed or heard of a problem there, and R8 had not reported pain as a reason. AD H was asked if they were aware R8 had a PTSD diagnosis. AD H reported they had not been made aware. When asked if that would change their approach to R8's activities, AD H stated, Yes, if we knew there was a (trauma) trigger it may change how we would provide something (an activity). I will talk with (R8) and we will go over the programs (to encourage their participation) . On 1/09/25 at 3:20 p.m., Surveyor shared the concerns related to R8's PTSD diagnosis, with self-reported adjustment concerns, limited care planning, no identification of triggers, and limited social services follow-up with the Director of Nursing (DON), with the Nursing Home Administrator (NHA) present. The DON reported in August (2024) the psychiatry provider had acknowledged R8 had nightmares which they addressed, and this was not a confirmed diagnosis, and provided documentation of the provider's 8/2024 visit. Surveyor explained on R8's MDS assessment and on their EMR diagnosis page PTSD was a diagnosis, and R8 themselves had confirmed they had a PTSD, however had not been asked triggers so the facility could follow-up. The DON denied a full PTSD diagnosis for R8 and said it had not been fully clarified and handed the surveyor the psych provider's 8/2024 visit. The NHA supported the DON's conclusions. (continued on next page)

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	235288	A. Building B. Wing	01/09/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Trauma Informed and Culturally Competent Care, Level III, reviewed 8/2024, revealed, Purpose: To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization .Trauma results from events, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being .Trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening .Traumatic events which may affect residents during their lifetime include: a. physical, sexual, and emotional abuse .For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization .Triggers are highly individualized. Some common triggers may include: .j. Experiencing a lack of privacy or confinement in a crowded or small space; k. exposure to loud noises, or bright/flashing lights. l certain sights, such as objects and/or m. sounds, smells, and physical touch .12. Select screening and assessment tools in collaboration with the QAPI (Quality Assurance and Performance Committee) .15. Establish an environment of physical and emotional safety for residents and staff .27. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate .28. Identify and decrease exposure to triggers that may re-traumatize the resident. 29. Recognize the relationship between past trauma and current health concerns, e.g. substance abuse, eating disorders, anxiety, and depression) .Resident Care Strategies. 31 . Safety. Ensure the residents have a sense of psychological, social, cultural, moral, and physical safety. Practice active listening without judgement .Recognize trust is earned over time. Individuals may not disclose information until a relationship has been established .Empowerment: Ensure the residents choices and preferences are honored and that residents are empowered to be active participants in their care . Review of the policy, Social Services, dated 9/2024, revealed, Our facility provides Social Services to assure each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. Policy Interpretation and Implementation: The Director of Social Services is a qualified social worker and is responsible for: .b. providing for the social and emotional needs of the resident and family .meeting or assisting with the medically-related social service needs of residents .y. Providing or arranging for mental and psychosocial counseling services, as needed . 5. Not all medically-related social services are provided by a qualified social worker. However, the facility is responsible for ensuring that all residents are provided these services whether by a staff member or through referrals to an outside agency .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation, interview, and record review the facility failed to ensure a medication error rate less than five percent when three medication errors were identified from a total of 41 opportunities for one resident (R104) of five residents observed during medication administration, resulting in a medication error rate of 7.32%. Findings include: Clinical record review revealed R104 was admitted to the facility on [DATE] with medical diagnoses including hypertension, heart failure, prostate cancer, thyroid disorder, and renal Insufficiency. Brief Interview of Mental Status (BIMS) scored 15/15 indicating R104 was cognitively intact. On 1/8/25, at 10:34 AM, Licensed Practical Nurse (LPN) A was reviewed for medication administration and was observed inaccurately measuring ordered 17 grams MiraLAX (a laxative medication) resulting in R104 receiving a lesser dose than ordered. On 1/8/25 at 4:12 PM, A medication reconciliation was conducted for R104 and revealed LPN A administered Metoprolol (heart failure, hypertension medication) 50 milligrams (mg) and failed to hold the medication based on ordered parameters to not administer if heartrate is less than 60 beats per minute. LPN 'A administered the medication with a documented heartrate of 57 beats per minute. During record review, R104 order for Flonase (allergy relief medication) one spray per each nostril was documented as administered at time of medication observation and the medication was not administered during this observation. On 1/8/25 at 2:16 PM, The Director of Nursing (DON) was informed of the above findings. The DON was shown the measuring cap of bottle of MiraLAX, and acknowledged the medication was not measured correctly resulting in R104 received a lower dose than what was ordered. The DON was informed R104's medication Flonase was not observed as given and documented by LPN A as administered. The DON further acknowledged R104's ordered Metoprolol parameters were not followed and the medication should not have been administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation and interview, the facility failed to ensure proper storage of medications for four of four medication carts reviewed for medication storage. Findings include: On 1/8/2024 at 8:52 AM, an observation of the 700-1 Medication Cart was conducted with Licensed Practical Nurse (LPN) B. The following medications were observed throughout the cart unpackaged and without patient identifiers. 1 WHITE ROUND TAB 1 1/4 TAB 1 WHITE OVAL 1 SMALL WHITE ROUND 1/Z 1 ROUND WHITE R/196 1 WHITE ROUND 1 PEACH ROUND EP102 2 OBLONG YELLOW NVR/17 3 PINK OBLONG 894/5 1 PEACH EP102 Insulin Pen (Humalog) observed with no patient identifier, only room [ROOM NUMBER] D written in black marker. On 1/8/2024 at 9:18 AM, an observation of the 600 Medication Cart was conducted with LPN C. The following medications were observed throughout the cart unpackaged and without patient identifiers. 1/2 WHITE TAB 3 PEACH ROUND EP102 1 WHITE ROUND AC41 2 ROUND WHITE EP116 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 OBLONG GREEN 45E1 1 WHITE ROUND 128C 3 YELLOW OBLONG 88H 1 WHITE ROUND G10 1 WHITE ROUND AC41 1 SMALL WHITE ROUND P5 1 ORANGE ROUND B302 1 HEXAGON BLUE 77 2 PINK 30LPIN 1 ORANGE OVAL B85 1 ROUND 196 1 ROUND 61 1 GREEN OBLONG 1 WHITE ROUND P20 On 1/8/25 at 9:18 AM, An observation of the 500 Medication Cart was conducted with LPN A. A total of nine medications were observed throughout the second drawer of the cart unpackaged and without patient identifiers. On 1/8/25 at 1:59 PM, The Director of Nursing (DON) was informed of the medication cart observations and acknowledged medications should not be stored without secured packaging and without patient identifiers. 38271 On 1/07/25 at approximately 10:44 a.m., a Medication Cart located next to room [ROOM NUMBER] was observed unlocked and unattended by any Nursing staff. On 1/7/25 at approximately 10:48 a.m., Nurse S was observed coming down the hall out of a residents room with a vital monitoring machine. Nurse S was queried if the medication cart should be locked and they indicated it should be and was observed locking it. A Review of the facility's policy titled; Storage of Medications dated 4/2019 documented the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility stores all drugs and biological's in a safe, secure, and orderly manner .Drugs are stored in the packaging, containers in which they are received .