STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235289	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41982 Based on interview and record review, the facility failed to ensure timely care and services to promote dignity in 1 (Resident #37) of 3 residents reviewed for dignity/respect, resulting in long call light wait times, delay in incontinence care, and the potential for feelings of diminished self-worth and frustration. Findings include: Resident #37 Review of a Resident Summary revealed Resident #37 was a male, with pertinent diagnoses which included: hemiplegia following cerebral infarction affecting left (left sided paralysis after a stroke), pain in left shoulder, and pain in right shoulder. Review of a Minimum Data Set (MDS) assessment for Resident #37, with a reference date of 7/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #37 was cognitively intact. Further review of said MDS revealed Resident #37 had a functional limitation in range of motion on one side for both upper extremity and lower extremity, that Resident #37 was frequently incontinent of bowel and bladder, and that Resident #37 was dependent on staff for toilet transfers. Review of a current Care Plan for Resident #37 revealed a focus of (Resident #37) needs assistance with daily ADL (activities of daily living) care due to CVA (stroke) with left sided weakness, DM (diabetes mellitus), physical debility, OA (osteoarthritis), bilateral (both sides) leg pain, potential communication and memory deficits with interventions which included, TOILETING: Extensive x2 (two-person), If he refuses toileting Check and Change Q2 (every two) hours and PRN (as needed) with a start date of 8/31/22 and I use the bathroom, but I am also incontinent of bladder and bowel. I use briefs with a start date of 12/9/22. In an interview on 8/27/24 at 12:52 PM, Resident #37 reported he wore a brief, and the staff did not change him as often as he needed to be changed. Resident #37 reported it took a long time for his call light to be answered. Resident #37 reported when he turned on his call light, sometimes he had to wait and wait and wait and they (referring to staff) don't come. Resident #37 reported when he was waiting for his call light to be answered when he needed a brief change, it was not a good feeling to have to sit in his waste. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/29/24 at 12:33 PM, Certified Nurse Aide (CNA) RR reported Resident #37 was not known to refuse care. CNA RR reported it happened a lot that residents had to wait for their call lights to be answered. CNA RR confirmed that Resident #37 has had to wait for his call light to be answered and his brief to be changed. CNA RR reported Resident #37 complained all the time about having to wait.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 1 of 24 residents (Resident #10) reviewed for accommodation of needs, resulting in the inability to call for staff assistance and the potential for unmet care needs. Findings include: Resident #10 Review of an Admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included osteoarthritis. Review of a Minimum Data Set (MDS) assessment for Resident #10, with a reference date of 7/4/24 revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #10 was severely cognitively impaired. Review of Resident #10's Care Plan revealed, .Communication: (Resident #10) is at risk for impaired communication related to change in environment .Interventions: .call light within reach. Date initiated: 11/30/23 . During an observation and interview on 8/27/24 at 12:18 PM, Resident #10 was lying in bed watching television. Resident #10 reported that she used her call light to ask for staff assistance, but she did not have her call light. Resident #10's call light was sitting in her recliner on the other side of her room and out of Resident #10's reach. During an observation and interview on 8/27/24 at 12:25 PM, Chaplain QQ entered Resident #10's room and confirmed that Resident #10's call light was out of Resident #10's reach. During an interview on 8/29/24 at 11:27 AM, Certified Nursing Assistant (CNA) KK reported that Resident #10 did use her call light to call for staff assistance when she needed assistance. Review of the facility's Call light policy last reviewed 1/2024 revealed, Purpose: The purpose of this procedure is to respond to the resident's request and needs. The community should be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to an associate or to a centralized work area .General Guidelines: E. When the resident is in bed or confined to a chair be sure the call light is within reach of the resident .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 36221 Based on observation, interview, and record review, the facility failed to ensure a clean and sanitary environment in 2 of 2 residents (Resident #53 & #54) reviewed for a clean, comfortable, homelike environment, resulting in soiled fans and the potential for respiratory complications. Findings include: Review of the policy/procedure High Profile Patient Room Cleaning, dated 2/1/22, revealed .High dust, beginning at the entranceway and working around the room in a circle. High dust horizontal surfaces above shoulder height starting opposite the restroom. Never dust above a patient/resident. High dust surfaces in the restroom .disinfect vertical surfaces including stains and spots from walls, light switches, door knobs and other relevant vertical surfaces . Resident #53 Review of a Profile Face Sheet revealed Resident #53 was a female, with pertinent diagnoses which included respiratory failure, heart failure, kidney disease, obstructive lung disease, vascular disease, high blood pressure, depression, and diabetes. In an observation on 8/27/24 at 11:41 AM, Resident #53 was in bed in her room. Noted a black pedestal fan near the foot of Resident #53's bed with visible dust buildup on the front and back surface of the fan grates. In an observation on 8/27/24 at 3:15 PM, Resident #53 was in bed in her room. Noted a black pedestal fan near the foot of Resident #53's bed with visible dust buildup on the front and back surface of the fan grates. Observed a housekeeper in Resident #53's room at this time, cleaning the floors. In an observation on 8/28/24 at 9:09 AM, Resident #53 was in bed in her room. Noted a black pedestal fan near the foot of Resident #53's bed with visible dust buildup on the front and back surface of the fan grates. In an interview on 8/28/24 at 3:05 PM, Housekeeper VV reported she cleans resident rooms at the facility. Housekeeper VV reported cleaning of fans is not part of the daily cleaning process. In an observation on 8/28/24 at 3:13 PM, Resident #53 was in bed in her room. Noted a black pedestal fan near the foot of Resident #53's bed with visible dust buildup on the front and back surface of the fan grates. In an observation on 8/29/24 at 1:24 PM, Resident #53 was in bed in her room. Noted a black pedestal fan near the foot of Resident #53's bed with visible dust buildup on the front and back surface of the fan grates. In an interview on 8/29/24 at 3:17 PM, Housekeeper WW reported fans in resident rooms should be cleaned routinely as part of the daily cleaning process. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	41982 Resident #54 Review of a Resident Summary revealed Resident #54 was a female, with pertinent diagnoses which included: obstructive sleep apnea, chronic leukemia, and allergic rhinitis. Review of a Minimum Data Set (MDS) assessment for Resident #54, with a reference date of 7/31/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #54 was cognitively intact. Further review of said MDS revealed Resident #54 received oxygen therapy. In an observation and interview on 8/27/24 at 12:02 PM, observed Resident #54 in her room lying in her bed. There was a portable fan positioned so that it was blowing directly toward the resident. There was a significant amount of dust collected on the grates and the blades of the fan. Resident #54 was queried about the frequency by which the facility cleaned the fan. Resident #54 stated, they don't clean it. In an observation on 8/28/24 at 12:15 PM, Resident #54 was observed in her room lying in her bed. The portable fan was on and blowing directly toward the resident. The fan had not been cleaned. In an observation on 8/29/24 at 12:42 PM, Resident #54 was observed in her room lying in her bed. The portable fan was on and blowing directly toward the resident. The fan had not been cleaned.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure staff fully implemented the abuse policy and report allegations of neglect to the abuse coordinator in a timely manner for 1 (Resident #6) of 1 residents reviewed for abuse and neglect, resulting in the potential for continued violations involving neglect go unreported. Findings include: Review of an Admission Record revealed Resident #6 was originally admitted to the facility on [DATE] with pertinent diagnoses which included parkisons disease. Review of Resident #6's Concern/Grievance form dated 8/27/24 revealed, Information about your concerns: On 8/27/24 (Resident #6) said that she was wet. The night aide came to change her at 6:10 PM. (Resident #6) was soaked and soiled. Her pants and her chair were soaked. The aide was so upset that she (Resident #6) had appeared to not had been changed at all during the day. She called (Licensed Practical Nurse Unit Manager (LPN-UM)) BB. This is not an isolated occurrence as her laundry is always soaked in urine. We do her (Resident #6's) laundry. I filed a complaint via email regarding the same incident on 8/10/24. I spoke with (LPN-UM BB and NHA A) Facility Response: (CNA V) not to be Resident #6's direct care provider. Swapped her out first thing in the morning on 8/28/24. Binder in nurses station to be filled out with rounding and signed/initialed. Nursing leadership to monitor and follow up as needed . Review of Resident #6's Concern/Grievance form dated 8/27/24 and completed by LPN-UM BB revealed, Information about your concerns: (Resident #6) daughter brought attention to the condition of Resident #6 last night. She showed me pictures of her pants, cushion, and brief. Pants wet, cushion wet, brief looked as tough too much urine was present for rounds to have been done in a timely fashion . How can we address your issue: (Resident #6's) daughter feels as though this is unacceptable, which I agree. She wants the aide held accountable . Facility response: Morning of 8/28/24: CNA V was informed that she could not care for Resident #6. Myself (LPN-UM BB and Director of Nursing (DON) B need to assess the situation. Spoke with Resident #6's daughter. Binder in the nurses station as of 8/28/24 for rounding, and care has to be signed by her staff . Action to be taken: Nursing leadership will monitor log and perform follow up as needed. During an interview on 8/29/24 at 11:52 AM, LPN-UM BB reported that she had been informed by a CNA and Resident #6's daughter that Resident #6 had been left wet and soiled in the evening on 8/27/24 so she completed a grievance form to address the concern the following day. LPN-UM BB reported that she did have concerns that Resident #6 had not been cared for based on the photos that Resident #6's family showed her. LPN-UM BB reported that did not report these allegations to NHA A until the following day. LPN-UM BB reported that she had also been made aware of the allegations that Resident #6 was left wet and soiled on 8/10/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 2:23 PM, Director of Nursing (DON) B reported that she had not been made aware of the allegations that Resident #10 was left wet and soiled on 8/10/24. DON B reported that she was aware of the allegations that Resident #6 had been left wet and soiled on 8/27/24. DON B confirmed that the CNA that was caring for Resident #6 on 8/27/24 was suspended pending an investigation into the allegations. DON B did not know if the allegations were reported to the state agency. During an interview on 8/29/24 at 2:45 PM, Nursing Home Administrator (NHA) A reported that she had learned about the allegations of Resident #6 being left wet and soiled on 8/28/24 during the facility's morning meeting. NHA A reported that she had also been made aware of the reported allegations on 8/10/24. NHA A reported that the facility had terminated the contract of the agency CNA that cared for Resident #6 on 8/10/24, but she had not completed any other follow up yet related to the allegations on 8/10/24. NHA A reported that the facility had suspended the CNA that was caring for Resident #6 on 8/27/24 pending an investigation. NHA A reported that they were investigating the allegations of Resident #6 being left wet and soiled for an extended period of time. NHA A reported that she had concerns for neglect based on the allegations she had received from Resident #6's family. Review of the facility's Abuse policy, last revised 8/2024 revealed, Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . Reporting/Response: A. The community will immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse of result in serious bodily injury, or not later than 24 hours if the events that cause allegation do not involve abuse and do not result in serious bodily injury, report alleged violation involving abuse, neglect, exploitation of property, to the administrator and or designee, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable)within specific time frames .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to report allegations of neglect to the State Agency in a timely manner for 1 (Resident #6) of 1 residents reviewed for abuse and neglect, resulting in the potential for continued violations involving neglect going undetected, unreported, or without thorough investigation. Findings include: Resident #6 Review of an Admission Record revealed Resident #6 was originally admitted to the facility on [DATE] with pertinent diagnoses which included parkisons disease. Review of Resident #6's Concern/Grievance form dated 8/27/24 revealed, Information about your concerns: On 8/27/24 (Resident #6) said that she was wet. The night aide came to change her at 6:10 PM. (Resident #6) was soaked and soiled. Her pants and her chair were soaked. The aide was so upset that she (Resident #6) had appeared to not had been changed at all during the day. She called (Licensed Practical Nurse Unit Manager (LPN-UM)) BB. This is not an isolated occurrence as her laundry is always soaked in urine. We do her (Resident #6's) laundry. I filed a complaint via email regarding the same incident on 8/10/24. I spoke with (LPN-UM BB and NHA A) Facility Response: (CNA V) not to be Resident #6's direct care provider. Swapped her out first thing in the morning on 8/28/24. Binder in nurses station to be filled out with rounding and signed/initialed. Nursing leadership to monitor and follow up as needed . Review of Resident #6's Concern/Grievance form dated 8/27/24 and completed by LPN-UM BB revealed, Information about your concerns: (Resident #6) daughter brought attention to the condition of Resident #6 last night. She showed me pictures of her pants, cushion, and brief. Pants wet, cushion wet, brief looked as tough too much urine was present for rounds to have been done in a timely fashion . How can we address your issue: (Resident #6's) daughter feels as though this is unacceptable, which I agree. She wants the aide held accountable . Facility response: Morning of 8/28/24: CNA V was informed that she could not care for Resident #6. Myself (LPN-UM BB and Director of Nursing (DON) B need to assess the situation. Spoke with Resident #6's daughter. Binder in the nurses station as of 8/28/24 for rounding, and care has to be signed by her staff . Action to be taken: Nursing leadership will monitor log and perform follow up as needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/29/24 at 11:52 AM, LPN-UM BB reported that she had been informed by a CNA and Resident #6's daughter that Resident #6 had been left wet and soiled in the evening on 8/27/24 so she completed a grievance form to address the concern the following day. LPN-UM BB reported that she did have concerns that Resident #6 had not been cared for based on the photos that Resident #6's family showed her. LPN-UM BB reported that did not report these allegations to NHA A until the following day. LPN-UM BB reported that the facility had suspended the CNA that was caring for Resident #6 on 8/27/24 as they investigated the allegations. LPN-UM BB reported that she had also been made aware of the allegations that Resident #6 was left wet and soiled on 8/10/24. LPN-UM BB reported that the facility was not allowing the agency CNA that was caring for Resident #6 on 8/10/24 to work at the facility anymore. LPN-UM BB did not know if the allegations from Resident #6's family were reported to the state agency. During an interview on 8/29/24 at 2:23 PM, Director of Nursing (DON) B reported that she had not been made aware of the allegations that Resident #10 was left wet and soiled on 8/10/24. DON B reported that she was aware of the allegations that Resident #6 had been left wet and soiled on 8/27/24. DON B confirmed that the CNA that was caring for Resident #6 on 8/27/24 was suspended pending an investigation into the allegations. DON B did not know if the allegations were reported to the state agency. During an interview on 8/29/24 at 2:45 PM, Nursing Home Administrator (NHA) A reported that she had learned about the allegations of Resident #6 being left wet and soiled on 8/28/24 during the facility's morning meeting. NHA A reported that she had also been made aware of the reported allegations on 8/10/24. NHA A reported that the facility had terminated the contract of the agency CNA that cared for Resident #6 on 8/10/24, but she had not completed any other follow up yet related to the allegations on 8/10/24. NHA A reported that the facility had suspended the CNA that was caring for Resident #6 on 8/27/24 pending an investigation. NHA A reported that they were investigating the allegations of Resident #6 being left wet and soiled for an extended period of time. NHA A reported that she had concerns for neglect based on the allegations she had received from Resident #6's family. NHA A confirmed that neglect allegations should be reported to the State of Michigan. NHA A reported that she did not report the allegations of neglect to the state agency because she just overlooked it. Review of the facility's Abuse policy, last revised 8/2024 revealed, Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . Reporting/Response: A. The community will immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse of result in serious bodily injury, or not later than 24 hours if the events that cause allegation do not involve abuse and do not result in serious bodily injury, report alleged violation involving abuse, neglect, exploitation of property, to the administrator and or designee, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable)within specific time frames .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48637 Based on interview and record review, the facility failed to provide written notification to the State Long-Term Care (LTC) Ombudsman of facility-initiated transfers/discharges since November 2019, resulting in the potential for all residents to be discharged without an advocate who can inform them of their options and rights. Findings include: On 8/23/2024 at 1:41 PM, an email was received from the State LTC Ombudsman (Ombudsman) I which stated, .They (Borgess Gardens) are not sending the required notices for transfer and discharges (to her). During an interview on 8/28/2024 at 11:53 AM, Director of Social Work (DSW) X and Social Worker (SW) II stated that they haven't been sending the required notices for transfers and discharges to the State LTC Ombudsman. SW II said that they used to send it to the Ombudsman monthly but they haven't sent the notices in a long time. During another interview on 8/28/24 at 12:03 PM, SW II stated that she found an email of the last notice of transfers and discharges that she sent to the State Ombudsman which was dated November 2019. During an interview on 8/29/2024 at 12:17 PM, Nursing Home Administrator (NHA) A stated that DSW X and SW II spoke to her about the transfer and discharges notices not being sent to the State Ombudsman. NHA A' said that they will start sending the notice list to the Ombudsman every 2 weeks moving forward. Review of the Transfer or Discharge, Preparing a Resident for Policy with an origination date of 12/2016 and a revision date of 11/2022 revealed Policy Interpretation and Implementation D. The social worker, or designee, is responsible for: Provide a copy of the notice to the Office of the State Long Term Care Ombudsman

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to implement care plan interventions and orders for 2 (Resident # 50 and #43) of 18 Residents reviewed for care planning, resulting in a potential for unmet care needs. Findings include: Resident #50 Review of an Admission Record revealed Resident #50 was originally admitted to the facility on [DATE] with pertinent diagnoses which included heart failure. Review of Resident #50's Care Plan revealed, . Nutritional Status: . Meal Assistance as needed. Date initiated: 6/27/23 . Review of Resident #50's Orders revealed, .Feeding Assistance with meals. Start date: 8/9/24 . During an observation on 8/28/24 at 12:35 PM, Resident #50 was sitting in the dining area with her lunch tray in front of her. Resident #50 was attempting to eat with a spoon. Resident #50 spilled all of the food contents from the spoon onto her lap several times. Resident #50 had several pieces of food on her shirt and pants. It was noted that there were no staff in the area to observe or assist Resident #50 with eating her meal. During an observation on 8/29/24 at 8:59 AM, Resident #50 was sitting in the dining area eating break without the assistance or supervision of staff. Resident #50 was struggling to eat the food on her plate, and frequently spilled food onto her clothing. During an interview on 8/29/24 at 9:01 AM, Licensed Practical Nurse (LPN) UU reported that she did not think that Resident #50 needed supervision or assistance with meals and that staff could leave Resident #50 in the dining area alone when eating. During an interview on 8/29/24 at 11:52 AM, LPN Unit Manager (LPN-UM) BB reported that speech therapy had placed the order for Resident #50 to have assistance with feeding, and she was not aware of why the order was needed. LPN-UM BB reported that since Resident #50 had an order for assistance with feeding, staff would be required during all meals. During an interview on 8/29/24 at 12:25 PM, Speech Pathologist (SP) XX reported that she had put in the order for Resident #50 to have assistance with meals because she had recently observed Resident #50 struggling to get food onto the utensils, and she would grab items that were not food. SP XX reported that she had recently had to stop Resident #50 from eating a ketchup packet. SP XX reported that Resident #50 should have assistance and supervision with eating meals for her own safety. 38384 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R43 According to the Minimum Data Set (MDS) dated [DATE], R43 was severely cognitively impaired with indication he was unable to complete his BIMS (Brief Interview Mental Status), required assistance with turning and positioning and had diagnoses that included Alzheimer's disease, age-related physical debility, muscle weakness, cognitive communication deficit, and repeated falls. Review of R43's Interdisciplinary Team Progress Note, dated 8/27/24, indicated the resident had a recent fall and was on Fall Precautions. Review of R43's Care Plan, Pressure Ulcers/Skin Prevention, dated 1/11/2024, with interventions that included, Roho in place on recliner with dycem on top and below to prevent. Review of R43's Medication Administration Record/Treatment Administration Record (MAR/TAR), dated August 2024, revealed Ensure roho cushion is in recliner with blue Dycem (help prevent unwanted movement) under and on top of cushion-every 12 hours for prevent slide out of recliner. Review of R43's MAR/TAR August 2024, (NOC (night) shift 20:00 (8 PM)) revealed, Ensure roho cushion is in recliner with blue Dycem under and on top of cushion-Every 12 hours for prevent slide out of recliner every 12 hours. Observed on: -8/27/24 at 8:05 AM, R43 sitting in his recliner with 2 blue Dycem silicone pads in seat with no roho cushion (dry floatation cushion) on top of Dycem pads. -8/28/24 at 11:44 AM, R43 sitting in his recliner with 2 blue Dycem silicone pads in seat with no roho cushion on top of Dycem pads. -8/28/24 at 2:25 PM, R43 was sitting in his recliner with 2 blue Dycem silicone pads in seat with no roho cushion on top of Dycem pads. During an interview on 8/29/24 at 3:45 PM, Unit Manager (UM) BB stated the ROHO cushion on R43's chair is .because he is so tiny . and wants to be in the recliner all the time. UM BB reported the ROHO cushion is to relieve pressure.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to assess a change of skin condition in 1 of 5 residents (R43) reviewed for quality of care, resulting in a delay in assessment, treatment, pain, and the potential for worsening of condition and infection. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R43 was severely cognitively impaired with indication he was unable to complete his BIMS (Brief Interview Mental Status), required assistance with turning/positioning, and had diagnoses that included Alzheimer's disease, age-related physical debility, muscle weakness, cognitive communication deficit, and repeated falls. Review of R43's MDS dated [DATE], Section M-Skin Conditions revealed the resident was at risk for pressure ulcers with an unhealed stage 3 and skin tears. Treatments/interventions for both pressure ulcer and skin tears included pressure ulcer care, and application of nonsurgical dressings. Review of R43's Physician Orders, dated 1/28/2022, revealed, Assess pain and document every shift. Review of R43's MAR/TAR August 2024, revealed, Geri sleeves to be in place bilateral forearms, covering elbows also check skin under sleeves every shift every 12 hours. Order start date 12/27/2023. Review of R43's MAR/TAR dated August 2024 revealed Weekly skin check (document results in skin and wound module) every week. On 8/27 Day shift, documentation stated this was done. It was noted R43 was noted to have blood saturated geri-sleeves on 8/27 and 8/28. Review of R43's MAR/TAR dated August 2024, indicated PAIN was to be monitored every day and NOC (night) shift. Review of R43's Care Plan, Pressure Ulcers/Skin Prevention dated 1/28/2022, indicated the resident was at risk for pressure ulcers and other skin related injuries with interventions that included Observe skin for redness and breakdown during routine care. Review of R43's Care Plan dated 1/28/2022, Pain, revealed the goal was for early detection of pain for timely interventions to prevent escalation. Interventions to meet this goal included reporting uncontrolled pain to provide and perform a comprehensive assessment of pain to include location, characteristics, onset, duration, frequency, quality, intensity, or severity, and precipitating factors of pain and to monitor for non-verbal signs of pain . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/27/24 at 1:19 PM R43 was sitting in a geri-chair (higher backed wheelchair) in the Tea Garden dining room. The resident had trousers that were just below his knee and wearing white socks. Observed the resident with multiple scabbed and open wounds with serosanguinous (bloody wound drainage) on bilateral (both) shins with no wound dressing. The right sock had fresh blood on it from the open wounds. The resident had geri sleeves (knit tubular sleeves) on both arms extending from hands to elbows. Below the right elbow was bruised skin with open areas that were not covered by dressings. Blood had saturated the right geri sleeve with the skin sticking to it. Certified Nursing Assistant (CNA) E CNA stated, (R43) will pick at his skin. He picks at his legs too. The CNA pulled down the right geri sleeve to reveal open areas that were oozing serosanguinous fluids. R43 flinched and said, Ow, ow and pulled his arm away. CNA E walked out of the room and did not come back. Observed on 8/27/24 at 2:55 PM, R43 was sitting in the Tea Garden dining room visiting with his hospice social worker. Both resident's shins had open oozing sores. Both lower arms had on geri-sleeves that had blood seeping through. Observed on 8/28/24 at 11:40 AM, R43 was sitting in his room. There was no wound dressing on the resident's right shin covering the open seeping sores. On the resident's left shin was a dressing dated 8/28. Both arms had on geri-sleeves with the right arm bleeding through the geri-sleeve that was stuck to the open wound the same spot and way it was the day before. During an observation and interview on 8/28/24 at 2:25 PM, R43 was sitting in his room. There was no dressing on his right shin that had open oozing sores. On left shin was a dressing dated 8/28. Both arms had geri-sleeves. The right arm was bleeding through the geri-sleeve that was stuck to the open wound in the same spots as earlier in the day and the day before. When the resident lifted his right arm and pulled on the geri-sleeve, flinched and he said loudly Ow! During an interview on 8/29/24 at 3:45 PM, Unit Manager (UM) BB stated, (R43) wears geri-sleeves because his skin is paper thin. He is wearing Kerlix (rolled gauze) today due to a skin tear that had a small amount of drainage and a dressing needed to be in place. The wound Nurse Practitioner saw the skin tear this morning. The measurements from that assessment still need to be entered. The skin tear was found last night and was only there for one day. The geri-sleeves are to be replaced when dirty or soiled. There is an order for every shift to place a covering over the elbows and check the skin.

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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** 47659 Based on observation, interview, and record review the facility failed to follow physician orders for use of oxygen for 1 (Resident #10) of 2 residents reviewed for respiratory care, resulting in inaccurate settings, irregular cleaning, and the potential for respiratory infection. Findings include: Resident #10 Review of an Admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pulmonary hypertension (high blood pressure that affects arteries in the lungs and in the heart). Review of Resident #10's Orders revealed, Change oxygen tubing weekly and label with date. Start date: 6/24/24 . Oxygen at 2 liters/minute per NC (nasal cannula) to keep sats (oxygen saturation) above 92% . During an observation on 8/27/24 at 12:18 PM, Resident #10 was lying in bed wearing her oxygen via nasal cannula. It was noted that Resident #10's oxygen was running at 3.5 liters/minute and the tubing on the oxygen tank was dated 8/19/24. During an observation on 8/28/24 at 8:59 AM, Resident #10 was lying in her bed. It was noted that Resident #10's oxygen was running at 3.5 liters/minute and the tubing on the oxygen tank was dated 8/19/24. During an interview on 8/29/24 at 11:25 AM, was lying in her bed. It was noted that Resident #10's oxygen was running at 3.5 liters/minute and the tubing on the oxygen tank was dated 8/19/24. During an interview on 8/28/24 at 1:15 PM: Infection Preventionist (IP) EE reported that the facility policy was for staff to change oxygen tubing every Saturday. IP EE reported that all oxygen tubing should have been dated for 8/24/24, and anything that was dated prior to 8/24/24 had not been changed. During an interview on 8/29/24 at 11:34 AM, Registered Nurse Unit Manager (RN-UM) HH reported that Resident #10 was ordered to have her oxygen running at 2 liters per minute, and that all oxygen tubing in the facility should have been changed on 8/24/24. RN-UM HH went to Resident #10's room with this surveyor and confirmed that Resident #10's oxygen was running at the incorrect rate, and that the tubing had not been changed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41982 Based on interview and record review, the facility failed to 1. provide documentation of an adequate indication for medication use, 2. educate the resident/guardian on the intended or actual benefit versus potential risk(s) or adverse consequences associated with the selected medication, and 3. identify, care plan, and implement non-pharmacological interventions for 1 (Resident #57) of 5 residents reviewed for unnecessary medications, resulting in the potential for unmet psychosocial needs and the resident to have received an unnecessary medication. Findings include: Resident #57 Review of a Resident Summary revealed Resident #57 was a female, with pertinent diagnoses which included: anxiety disorder, unspecified. Review of a Physician's Order for Resident #57 revealed, Order Date 02/15/24, Start Date 3/01/24 Zoloft 25 mg (milligram) tablet (Sertraline) - 1 tablet By Mouth Every Day for anxiety Review of Resident #57's current Care Plan revealed a focus of (Resident #57) has a mood state problem related to Anxiety and the entirety of care planned interventions for this focus which included, Administer antianxiety medication as ordered and monitor for adverse side effects; Observe and document effectiveness of mood enhancement medication (Zoloft); and Monitor behaviors and observe for patterns or triggers all of which had a start date of 4/3/24. In an interview on 8/28/24 at 1:59 PM, Social Worker (SW) II reported when a resident was started on an anti-anxiety or anti-depressant medication, the facility should obtain consent from the resident (or responsible party) before starting the medication. SW II reported that Resident #57 was SW AAA's resident and that SW AAA would be able to provide specific information about Resident #57. In an interview on 8/29/24 at 12:05 PM, SW AAA reviewed Resident #57's Physician's Order with this surveyor and reported the anxiety diagnosis listed in the Physician's Order for Resident #57's Zoloft was incorrect. SW AAA reported Resident #57's son seemed to think the Zoloft was started because Resident #57 had been having pain related to wounds she had when she was admitted to the facility. SW AAA was queried regarding what non-pharmacological interventions were identified and implemented to manage Resident #57's anxiety. SW AAA reviewed Resident #57's current Care Plan for anxiety and reported there were no non-pharmacological interventions listed. On 8/29/24 at 1:00 PM, electronic correspondence was sent to Nursing Home Administrator (NHA) A requesting documentation related to Resident #57's Zoloft use which included: a detail of what non-pharmacological interventions were identified and implemented for Resident #57 prior to initiation of the medication, and documentation of the consent for use of the medication including risk/benefit education for Resident #57/responsible party. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 1:25 PM, NHA A provided a copy of a physicians Progress Note dated 2/15/24, and Interdisciplinary Notes dated 2/15/24, 1/10/24, and 1/9/24. None of the documentation provided addressed Resident #57's Zoloft use or anxiety diagnosis. There was no documentation of consent for use including risk/benefit education for Resident #57/responsible party provided. In an interview on 8/29/24 at 1:52 PM, NHA A reported there was no additional documentation related to non-pharmacological interventions for Resident #57 prior to initiation of the Zoloft, and no documentation of the consent for use of the medication including risk/benefit education for Resident #57/responsible party.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents. Findings include: During the initial tour of the kitchen, at 9:35 AM on [DATE], observation of the walk-in cooler found some storage racks had heavy accumulation of gunk debris between portions of the shelf and the flat storage surface. Once the surfaces were pointed out to Director of Dining Services (DDS) N, he stated they needed to be cleaned. During the initial tour of the kitchen, at 9:41 AM on [DATE], an interview with DDS N found that clean utensil are stored in bins next to the hand sink. Observation of two clean utensil bins containing mechanical scoops and spoons found an increased amount of crumb debris present in the bottom of the bins. DDS N stated they should be getting cleaned weekly. During the initial tour of the kitchen, at 9:43 AM on [DATE], observation of the meat slicer found it covered in plastic. An interview with DDS N found that they don't use the slicer much. Observation of the slicer found increased accumulation of dried meat debris on the back underside of the blade and on the back top portion of the slicer blade. When asked if he could see the debris accumulation, DDS N stated yes. Observation of the can opener, at 9:50 AM on [DATE], found increased amounts of debris on the blade of the opener and a sticky substance on the handle and rail of the opener. At this time DDS N took the can opener to the dishwasher and ran it through. During the initial tour of the facility, at 9:55 AM on [DATE], it was observed that the bottom door gasket on the two door Traulson cooler was found with an increased amount of black debris. During the initial tour of the kitchen, at 10:05 AM on [DATE], observation of the Traulson two door freezer found increased black debris in the top door gaskets and an increased accumulation of crumb and breading debris in the bottom floor of the unit. According to the 2017 FDA Food Code section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. An interview with DDS N at 10:10 AM on [DATE], found that the kitchen did not have any test strips that were not expired and that he would have to get some. Currently there was no way for the kitchen to ensure proper concentration of the quaternary ammonium sanitizer they were using. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the Heirloom Bistro, at 11:20 AM on [DATE], found a set of sanitizer quaternary ammonium test strips with an expiration date of [DATE]. According to the 2017 FDA Food Code section ,d+[DATE].14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview and record review, the facility failed to fully implement a policy regarding use and storage of resident foods brought in from outside sources in one resident personal refirgerator (Resident #53) and one of four shared resident refrigerators. This deficient practice resulted in unknown discard dates and potentially hazardous foods being held passed their discard date, increasing the risk of contamination and food borne illness among residents who store personal food in the facility. Findings Include: An interview with Director of Dining Services (DDS) N at 10:18 AM on [DATE], regarding the four bistro areas of the facility, found that kitchen staff stock the bistro kitchen refrigeration units once a day and that housekeeping staff should clean the bistro once a day. When asked who takes care of resident food from outside sources, DDS N stated that nursing staff takes care of the labeling and dating of that product and it goes in the separate resident fridge which each bistro has. During a tour of the Heirloom Garden Bistro, at 11:18 AM on [DATE], observation of the resident refrigeration unit found the following items: a container of mac and cheese dated ,d+[DATE], a strawberry banana fruit drink that stated Enjoy by [DATE], A bottle of 2% milk with a best by date of [DATE], a grocery bag that contained an open chef salad that stated Fresh thru [DATE] and an unopened container of mac and cheese that stated Fresh thru [DATE]. 36221 Review of the policy/procedure Foods Brought by Resident Representative(s)/Visitors and Personal Refrigerators, dated ,d+[DATE], revealed .It is the policy of (Facility Name) that outside food may be brought for residents by resident representative(s)/visitors .Associates assist the resident in accessing and consuming the food, if the resident is not able to do so on his or her own .Perishable foods brought into the community and stored in the kitchenette refrigerators or the resident's room shall be clearly marked with the resident's name and .leftover foods shall be marked with today's date and used for up to 3-days (72 hours) . food items labeled with an expiration date shall be marked with the date opened and stored until the expiration date .be discarded if food item shows obvious signs of potential foodborne danger (for example, mold growth and foul odor) .The resident room refrigerators will be monitored by a community designated associate for outdated/expired food and these associates shall also monitor proper refrigerator temperatures . Food stored in resident room refrigerators shall follow the same guidelines as food stored in the kitchenette refrigerator for labeling and discarding . Resident #53 Review of a Profile Face Sheet revealed Resident #53 was a female, with pertinent diagnoses which included respiratory failure, heart failure, kidney disease, obstructive lung disease, vascular disease, high blood pressure, depression, and diabetes. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #53, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. In an observation and interview on [DATE] at 11:41 AM, Resident #53 was in bed in her room. Noted an extensive supply of personal food items in Resident #53's room, along with a small dorm-style refrigerator on the floor, along the wall across from Resident #53's bed. Resident #53 reported she stores personal food items in the fridge. Resident #53 reported staff occasionally check the food items in the fridge for expiration when they have time, and stated .right now it needs to be cleaned out. I have something in there that's rotting. I can smell it when they open it. I think it's one of my vegetables . Noted a temperature log on the top of Resident #53's fridge with 14 missed daily temperature entries for the month of [DATE]. Opened the small dorm-style fridge with Resident #53's permission and observed the fridge was completely packed full with personal food items. Noted a noxious smell coming from within the fridge. Resident #53 reported she was unsure if any of the food items were dated and was unsure which items were expired. Noted spilled food debris on the door shelves of the small dorm-style fridge. Resident #53 became upset by the smell coming from the refrigerator and requested the door be closed. In an observation and interview on [DATE] at 9:09 AM, Resident #53 was in bed in her room. Noted an extensive supply of personal food items in Resident #53's room, along with a small dorm-style refrigerator on the floor, along the wall across from Resident #53's bed. Resident #53 reported no staff have checked her refrigerator or removed any expired food items since the prior observation. In an observation and interview on [DATE] at 11:21 AM, Resident #53 was in bed in her room. Observed Agency Licensed Practical Nurse (LPN) J enter Resident #53's room to clean out the small dorm-style refrigerator. Noted an opened bag of sugar snap peas with no open date. Agency LPN J stated the sugar snap peas .looked frozen . and threw them in the trash. Resident #53 stated .if you don't know what it is throw it out . Observed Agency LPN J discard a sausage with a large amount of visible green/white mold on the side. Noted an unidentified item stored in a disposable nitrile glove that was discarded by Agency LPN J, along with a bag of pepperoni that Agency LPN J stated .looks questionable . Agency LPN J reported she was unsure who was responsible to clean and check dates for food stored in resident personal refrigerators. Agency LPN J reported she cleaned Resident #53's refrigerator because it was something Resident #53 asked her to do. In an interview on [DATE] at 1:56 PM, Unit Manager BB reported the facility is aware of an issue related to the storage of food items in personal refrigerators, and intends to develop and implement a new process going forward.

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	235289	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed to ensure proper hand hygiene was performed during brief change and wound dressing change, resulting in the potential for bacterial harborage, cross contamination, and the spread of disease to a vulnerable population. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R43 was severely cognitively impaired with indication he was unable to complete his BIMS (Brief Interview Mental Status), required assistance with turning / positioning, brief changes, and had diagnoses that included Alzheimer's disease, age-related physical debility, muscle weakness, and cognitive communication deficit. Review of R43's MDS dated [DATE], Section M-Skin Conditions revealed the resident had an unhealed stage 3 pressure ulcer and skin tears. Treatments/interventions for both pressure ulcer and skin tears included wound care, and application of nonsurgical dressings. Review of R43's Physician Orders, dated 7/22/2024 revealed, Medi honey to coccyx wound-dime size everyday cleanse with NS, pat dry, apply Medi honey. Apply bordered dressing. Review of R43's Physician Orders, dated 4/20/24, revealed, Enhanced Barrier Precautions (EBP) for resident care continuous for pressure wound to coccyx area/wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/27/24 at 3:06 PM Registered Nurse (RN) F gathered supplies including multiple clean gloves and entered R43's room to perform a wound dressing change to his coccyx. The resident was in bed on top of bedding with his legs and hips swiveled to the left. There was no barrier between the resident and the bedding. The RN pulled R43's pants down in the back to expose his brief then donned PPE including a mask, gown, and gloves. RN F wiped off a bedside table and placed a paper towel as a barrier on a portion of the table. The RN doffed her gloves and donned new gloves with her fingernails breaking through. RN F was wearing artificial nails extending 1/4 past fingertips. Without performing hand hygiene, the RN donned another pair of gloves. RN F placed MediHoney, NS (normal saline for cleansing wound), gloves, measuring tape, and super fluff on the table. Without a barrier, RN F pulled down R43's pants farther and opened his brief. While using wipes to clean the resident's genitals, he stated, I don't want that cold stuff. The RN had the resident turn farther towards window and with wipes cleaned BM (bowel movement) from him. The RN and folded the soiled brief farther under him with still no barrier. After cleaning R43, RN F doffed gloves and donned clean gloves and put a clean brief under the resident with no barrier under resident. The RN threw away the soiled brief and doffed her glovesf. [NAME] throwing away the soiled brief, the RN donned clean gloves without performing hand hygiene. During this time, R43 tried to cover up his bottom with the blanket he was lying on. Using NS and a fluffed gauze, the RN cleaned the open area at the top of his coccyx. She removed the gloves she used to clean the wound, and without hand hygiene donned a new pair and used a measuring tape and swab to get dimensions of wound. According to RN F, the coccyx wound measured 1.7cm x 0.5 cm x 0.3 cm in depth. The RN doffed gloves and without performing hand hygiene, donned clean gloves, took a marker and dated the dressing 8/27. RN F looked for a clean swab and without finding one on the table, she applied Medihoney to the tip of her finger using the same gloves she had used to date the dressing, it over the wound, and placed the dressing over the wound. While still wearing the gloves, the RN had R43 roll to his right side, pulled his brief under him, fastened the brief, pulled his trousers up adjusting them as resident rolled to his left. The resident's trousers were urine soaked. The RN removed the urine-soaked trousers and placed them in yellow container labeled for soiled clothing. During this time, the resident attempted to cover himself again using the blanket he was lying on. Wearing the same gloves, RN F moved the resident's geri-chair (high backed wheelchair), opened the clothes closest, grabbed a clean pair of trousers, and placed them on the resident. Then the RN took the resident's shoes with gloved hands and put them on resident. At this time, CNA V entered the room assisting RN F to pull up the resident's trousers. RN F stated, Hand hygiene and glove changes should be done before and after brief change and anytime staff goes from soiled to clean gloves should be changed and hand hygiene should be done. I did hand hygiene before I started with (R43). He did not have an old dressing on when I started. The dressing should have been changed daily. I do not remember if I did hand hygiene when I changed my gloves or not.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure residents were screened for eligibility to receive pneumococcal vaccinations and receive vaccination if eligible for 1 (Resident #2) of 5 residents reviewed for vaccinations, resulting in the potential of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. Findings include: Resident #2 Review of an Admission Record revealed Resident #2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertensive heart disease with heart failure. Review of Resident 2's Immunization Record revealed that Resident # 2 had not received the Pneumococcal vaccine. Review of Resident #2's Vaccine History and Consent form dated 10/2/22 revealed that Resident #2 wished to receive the CDC recommended Pneumococcal vaccine . During an interview on 8/28/24 at 1:00 PM, Infection Preventionist (IP) EE reported that Resident #2 was currently due and eligible for an updated Pneumococcal vaccine. IP EE reported that the facility had missed assessing and administering the vaccine to Resident #2.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure COVID-19 immunizations were offered to 3 of 5 residents (Resident #2, #50 and #53) reviewed for COVID-19 immunizations, resulting in an increased risk for infection, and the potential spread of COVID-19 infection to other residents, staff, and visitors. Findings include: Resident #2 Review of an Admission Record revealed Resident #2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertensive heart disease with heart failure. Review of Resident #2 Immunization Record revealed that Resident #2 had not received a Covid-19 vaccine. Review of Resident #2's Vaccine History and Consent form dated 10/2/22 revealed that Resident # 2 had wished to receive the Covid-19 vaccination During an interview on 8/28/24 at 1:00 PM, Infection Preventionist (IP) EE reported that Resident #2 was currently due and eligible for an updated Covid-19 vaccine. IP EE reported that the facility had missed assessing and administering the vaccine to Resident #2. Resident #50 Review of an Admission Record revealed Resident #50 was originally admitted to the facility on [DATE] with pertinent diagnoses which included heart failure. Review of Resident #50's Immunization Record indicated that Resident #50 did not receive a Covid-19 vaccine in 2023. Review of Resident #50's Vaccine History and Consent form which did not indicate a date revealed that Resident #50 had indicated that she would like to receive a Covid-19 vaccination During an interview on 8/28/23 at 1:00 PM, IP EE reported that she did not know why Resident #50 did not receive a Covid-19 vaccine in 2023. IP EE was not able to provide evidence that Resident #50 had been offered the Covid-19 vaccine in 2023 and reported that the facility must have missed this. Resident #53 Review of an Admission Record revealed Resident #53 was originally admitted to the facility on [DATE] with pertinent diagnoses which included acute and chronic respiratory failure with hypoxia. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's Immunization Record revealed that Resident #53 had not received a Covid-19 vaccination in 2023. Review of Resident #53's Vaccine History and Consent form dated 11/21/22 revealed that Resident #5 had declined to receive the Covid-19 vaccine in 2022. During an interview on 8/28/23 at 1:00 PM, IP EE reported that the facility should have offered Resident #53 the Covid-19 vaccine in 2023 even if she had declined the vaccine in 2022. IP EE reported that the facility should have completed a new Vaccine History and Consent form for 2023, but she was not able to find this form. IP EE did not know if Resident #53 had been offered the Covid-19 vaccine in 2023. The facility was not able to provide any additional documentation to verify that residents were offered the Covid-19 vaccine in 2023 prior to survey exit.