STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste Marie	1011 Meridian Rd Sault Sainte Marie, MI 49783

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 0600

Level of Harm - Actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49302

This deficiency pertains to Complaint Intake MI00145750 and Facility Reported Incident (FRI) MI00145875.

Based on observation, interview, and record review, the facility failed to prevent two separate incidents of resident-to-resident sexual abuse for four Residents (Residents #1, #2, #4, and #5) of nine residents reviewed for abuse and neglect. This deficient practice resulted in psychosocial harm when Resident #2 experienced ongoing feelings of embarrassment, anxiety, and fear.

Findings Include:

Resident #2 (R2):

Review of R2's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including quadriplegia (paralysis that affects all limbs and body from the neck down), dysarthria (difficulty speaking), adjustment disorder with anxiety, and post-traumatic stress disorder (PTSD). Record review of R2's most recent Minimum Data Set (MDS) assessment, dated 6/21/24, revealed a Brief Interview for Mental Status (BIMS) score of 9, indicative of moderate cognitive impairment.

Resident #1 (R1):

Review of R1's EMR revealed initial admission to the facility on [DATE] with diagnoses including dementia and personal history of behavioral disorders. Record review of R1's most recent MDS assessment, dated 7/2/24, revealed a BIMS score of 5, indicative of severe cognitive impairment.

Review of the FRI submitted to the SA included an incident summary which read, in part:

Residents [R2] and [R1] were in the dining room together when [R2] reported that [R1] was rubbing her hair then her leg and started rubbing towards her private area and she told him to stop . The police were notified as the alleged complaint was sexual abuse. [Licensed Practical Nurse (LPN) J] interviewed [R2] who stated I told him [R1] to stop, and he did not stop and touched my vaginal area . [R2] does have PTSD as she has a history of being a victim of sexual assault which has triggered from this event .She [R2] was strangled and left for dead in 1983 and was also assaulted from a partner .

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Sault Ste Marie		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 Meridian Rd Sault Sainte Marie, MI 49783	

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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 0600 Level of Harm - Actual harm Residents Affected - Few	On 7/23/24 at 11:15 AM, an interview was conducted with R2 who verified the allegation details. R2 stated, Another resident, [R1], touched me inappropriately .touched my hair and private area. I told him to stop .he didn't stop . it made me feel bad and embarrassed. I didn't want to say anything or talk about it because I was embarrassed . On 7/23/24 at 1:49 PM, an interview was conducted with Activities Director (AD) K who verified she was the staff member whom R2 reported the altercation. Activities Director (AD) K stated R2 reported R1 rubbed her hair, leg, and vaginal area and did not stop despite R2's request to do so. On 7/23/24 at 2:10 PM, an interview was conducted with Social Services Director (SSD) L who verified R2's history of domestic abuse, rape, and strangulation that resulted in PTSD. Social Services Director (SSD) L confirmed R2 experienced prolong feelings of embarrassment following the incident with R1. When asked if R1 exhibited similar inappropriate behaviors in the past, SSD L stated, one other time. Review of an Incident and Accident reported dated 3/30/24, previously investigated by the State Agency (SA), revealed R1 was observed rubbing the buttocks of a female resident, R6, in her private room. On 7/23/24 at 3:01 PM, an interview was conducted with LPN J who confirmed she observed R1 sitting awfully close to R2 in the dining room around the time of the incident. LPN J continued R1 and R2 were sitting, too close for comfort. LPN J stated she removed R1 from the dining room but was not aware R1 had already made physical contact with R2. Review of R2's progress notes revealed the following entries: 1. 7/16/24: Social services met with [R2] to follow up on alleged incident that occurred on 7/15/24 .She did express that she was embarrassed of the incident . 2. 7/17/24: Social Services spoke with [R2] regarding the alleged incident that occurred on 07/15/24 .She expressed that she was still embarrassed about the incident . Review of R2's Plan of Care revealed the following focus, initiated 8/18/23: Resident has an impaired mood/psychiatric status related to depression, PTSD. Res [resident] states not known triggers - staff states resident gets very upset with things she perceives as sexual ie; if people [NAME] at her, blow her a kiss etc can make her feel threatened r/t [related to] her past hx [history]. R2 plan of care reflected no updated interventions following the event with R1 on 7/15/24. Review of a police report from the local law enforcement agency read, in part: (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 0600 Level of Harm - Actual harm Residents Affected - Few	.on 7/15/24 at approximately 1728 hours [5: 28 PM], Officers were advised of a possible inappropriate touching that occurred at the senior living center . I personally investigated a similar situation with the same subject . I spoke with [R2] . [R2] advised that [R1] toucher [sic] her hair and her leg. [R2] advised [R1] tried to reach under her blank and touch her vagina . [R1's Legal Guardian M] advised this is the 2nd time she's been called from something like this . [Guardian M] advised there is a serious staffing problem here at [facility name] . On 7/23/24 at 2:10 PM, an interview was conducted with Legal Guardian M who verified a previous incident occurred between R1 and a separate resident. Legal Guardian M stated R1 was not supposed to be in the dining room due to similar past behaviors. Legal Guardian M advised, The facility is understaffed. Review of R1's plan of care revealed the following intervention, initiated 8/7/23: **RESIDENT IS NOT TO EAT IN DINING ROOM AT ANY TIME** . Review of R1's behavioral symptom charting in the days leading up to the incident with R2 on 7/15/24 indicated R1 exhibited 7 instances of grabbing, one instance of threatening behavior, and 13 instances of sexually inappropriate behavior in a 21-day look-back period. Review of R1's Kardex (a documentation system that enables direct-care staff to easily reference key patient information that direct their nursing care) did not reveal R1's history of sexually inappropriate behavior nor did it outline any behavioral interventions. On 7/23/24 at approximately 3:00 PM, an interview was conducted with Regional Director of Clinical Services H regarding the incident between R1 and R2. When asked how direct-care staff were made aware of R1's behavioral history, Regional Director of Clinical Services H indicated staff is alerted to previous history by word-of-mouth. Regional Director of Clinical Services H was asked how new staff would be aware of R1's history if not reported during every shift change to which she replied, It is assumed they know given he is a 1:1 [receiving direct supervision from 1 staff member]. When asked if staff would be better equipped to prevent future incidents if R1's history was reflected in his Kardex, Regional Director of Clinical Services H replied, I hear what you're saying. Regional Director of Clinical Services H was unsure why R1 was stationed in the dining room at the time of the 7/15/24 incident, despite his care planned intervention to not eat in the dining room. Resident #4 (R4): Review of R4's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Alzheimer's Disease and diabetes. Record review of R4's most recent MDS assessment, dated 5/20/24, revealed a BIMS score of 7, indicative of severe cognitive impairment. Resident #5 (R5): Review of R5's EMR revealed admission to the facility on [DATE] with diagnoses including vascular dementia, congestive heart failure, and adjustment disorder with anxiety. Record review of R5's most recent MDS assessment, dated 5/20/24, revealed a BIMS score of 13, indicative of intact cognition. (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

On 7/30/24 at 10:30 AM, a telephone interview was conducted with Certified Nursing Assistant (CNA) O regarding the protocol for reporting allegations of abuse. CNA O stated during a shift on 7/30/24 she walked into R5's room and observed him lying in bed with his pants pulled down and genitalia exposed. CNA O stated she observed R4 standing beside the bed. When asked if a sexual act was being performed, CNA O stated, I'm not entirely sure . I don't think so. R5 had a washcloth near so she may have been performing peri-care. When asked her next steps, CNA O stated she notified the floor nurse on duty, LPN A, and informed Regional Director of Clinical Services G by telephone. CNA O stated, I was really upset by the whole thing.

Review of R4 and R5's EMR revealed no documentation of the event.

On 7/30/24 at 12:12 PM, a telephone interview was conducted with LPN A who vaguely recalled the incident. LPN A stated that she informed the Director of Nursing (DON) but did not document the allegation. When asked why the incident was not documented, LPN A stated, The days are just too busy. I don't have time. I usually have around 29 residents to care for.

On 7/30/24 at 11:40 AM, an interview was conducted with Regional Director of Clinical Services G who verified she received a call from CNA O on 7/14/24 with details regarding the incident between R4 and R5. Regional Director of Clinical Services G stated she informed CNA O to notify the abuse coordinator. When asked if she had any further involvement, Regional Director of Clinical Services G stated, It's a new building for me, so I don't know the residents. That why I told her [CNA O] to follow up with the abuse coordinator. When asked if there was any follow-up following the allegation, Regional Director of Clinical Services G stated, There was a call, but I don't know what came of it.

Review of facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/24 read, in part:

.The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: .establishing a safe environment .by establishing policies and protocols for preventing sexual abuse .

Review of facility policy titled, Residents' Rights and Quality of Life, revised 1/1/22 read, in part:

.Our residents have the right .to be free from verbal, sexual, physical and mental abuse .

Review of facility policy titled, Trauma Informed Care, revised 10/30/23 read, in part:

.the facility will account for residents' experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Potential causes of re-traumatization by staff may include . Failing to provide adequate safety . Care plans will be initiated/updated to address those identified. Individualized approaches will be identified, and interventions put into place .

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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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 49302 This deficiency pertains to Complaint Intake MI00145457. Based on interview and record review, the facility failed to report an employee's criminal conviction to the Stage Agency (SA). This deficient practice resulted in the potential to jeopardize the safety and welfare of all 69 residents of the facility. Findings include: On 7/25/24 at 9:24 AM, a phone interview was conducted with a confidential staff member who expressed concern that a different confidential employee [Confidential Staff R] had a criminal conviction involving brandishing a firearm in public that was unknown to facility administration. The confidential staff member verbalized concern regarding the safety of the facility residents. On 7/30/24 at 11:40 AM, an interview was conducted with the Nursing Home Administrator (NHA), Regional Director of Clinical Services G, and Regional Director of Clinical Services F who stated they were unaware of Confidential Staff R's criminal conviction. The NHA stated, We [administration] were under the impression the charges were dropped. On 7/30/24 at approximately 11:55 AM, an interview was conducted with the Confidential Staff R who verified the criminal conviction. Confidential Staff R asserted previous administration was notified of the charge. No evidence of notification to previous or current administrative staff was provided by the time of survey exit. Review of the Facility Employee Handbook, dated January 2024 read, in part: .All employees are required to immediately notify their Facility Administrator of any arrests and any convictions of any kind . Review of facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/24 read, in part: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident .The facility will have written procedures that include: .Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service .

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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 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** 49302 This deficiency pertains to Complaint Intake MI00145750. This Deficient Practice Statement (DPS) has two parts: A and B. DPS A: Based on interview and record review, the facility failed to report an allegation of potential sexual abuse for one Resident (#5) of nine residents reviewed for abuse. This deficient practice resulted in no investigation into the allegation of abuse by the State Agency (SA) and the potential for continued abuse. Findings include: Resident #4 (R4): Review of R4's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Alzheimer's Disease and diabetes. Record review of R4's most recent MDS assessment, dated 5/20/24, revealed a BIMS score of 7, indicative of severe cognitive impairment. Resident #5 (R5): Review of R5's EMR revealed admission to the facility on [DATE] with diagnoses including vascular dementia, congestive heart failure, and adjustment disorder with anxiety. Record review of R5's most recent MDS assessment, dated 5/20/24, revealed a BIMS score of 13, indicative of intact cognition. On 7/30/24 at 10:30 AM, a telephone interview was conducted with Certified Nursing Assistant (CNA) O regarding the protocol for reporting allegations of abuse. CNA O stated during a shift on 7/30/24 she walked into R5's room and observed him lying in bed with his pants pulled down and genitalia exposed. CNA O stated she observed R4 standing beside the bed. When asked if a sexual act was being performed, CNA O stated, I'm not entirely sure . I don't think so. R5 had a washcloth near so she may have been performing peri-care. When asked her next steps, CNA O stated she notified the floor nurse on duty, LPN A, and informed Regional Director of Clinical Services G by telephone. CNA O stated, I was really upset by the whole thing. Review of R4 and R5's EMR revealed no documentation of the event. On 7/30/24 at 12:12 PM, a telephone interview was conducted with LPN A who vaguely recalled the incident. LPN A stated that she informed the Director of Nursing (DON) but did not document the allegation. When asked why the incident was not documented, LPN A stated, The days are just too busy. I don't have time. I usually have around 29 residents to care for. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 11:40 AM, an interview was conducted with Regional Director of Clinical Services G who verified she received a call from CNA O on 7/14/24 with details regarding the incident between R4 and R5. Regional Director of Clinical Services G stated she informed CNA O to notify the abuse coordinator. When asked if she had any further involvement, Regional Director of Clinical Services G stated, It's a new building for me, so I don't know the residents. That why I told her [CNA O] to follow up with the abuse coordinator. When asked if there was any follow-up succeeding the allegation, Regional Director of Clinical Services G stated, There was a call, but I don't know what came of it. On 7/30/24 at approximately 11:50 AM, an interview was conducted with the Nursing Home Administrator (NHA) regarding his expectation on reporting allegations of sexual abuse. The NHA stated all allegations of abuse should be reported to him immediately. After a brief investigation, the NHA stated the allegation should be reported to the SA. When asked if the incident between R4 and R5 should have been reported to the SA, the NHA replied, Yes. DPS B: This deficiency pertains to Facility Reported Incident (FRI) MI00145815. Based on interview and record review, the facility failed to provide an accurate investigation regarding the elopements for two Residents #4 and #5 (R4, R5) of three residents reviewed for elopement. Resident #4 (R4): Review of R4's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Alzheimer's Disease and diabetes. Record review of R4's most recent Minimum Data Set (MDS) assessment, dated 5/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicative of severe cognitive impairment. Resident #5 (R5): Review of R5's EMR revealed admission to the facility on [DATE] with diagnoses including vascular dementia, congestive heart failure, and adjustment disorder with anxiety. Record review of R5's most recent Minimum Data Set (MDS) assessment, dated 5/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicative of intact cognition. Review of the FRI submitted to the SA included an incident summary which read, in part: .On 7/13/24, [R4] had assisted [R5] outside of the facility by a door held open by a visitor. Staff outside witnessed the residents and went to accompany them back into the facility. Another visitor saw them exit the facility and notified the nurses . Per the camera footage, residents [R5] and [R4] were outside on the sidewalk 7 minutes in which at that time they were accompanied inside the facility with staff . The wanderguard bracelets were removed per [R4], she took it off as they were annoying . The alarm did not go off in the facility as a visitor held the door open. Through investigation it was shown that this was not a true elopement as the visitor did open and hold the door open and the residents were wanting to go for a walk outside . This was not an elopement . (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 9:49 AM, a phone interview was conducted with Registered Nurse (RN) B who confirmed she was receiving report from Licensed Practical Nurse (LPN) A at the nurse's circle when a facility visitor approached them and stated, Do you know [R4 and R5] are outside? RN B stated she and LPN A immediately responded and, [R4 and R5] were nowhere to be found. RN B continued, We went to the end of the driveway and then to the left where there's an adjacent side road. RN B stated Certified Nursing Assistant (CNA) C was approaching R4 and R5 after spotting them when leaving work. RN B stated, I kept thinking to myself, how is this possible? They are supposed to have wanderguards. RN B stated after examination, neither R4 nor R5 had wanderguards donned. On 7/24/24 at 2:41 PM, an interview was conducted with CNA C who confirmed she observed R4 pushing R5 in a wheelchair in the roadway when she was exiting the employee parking lot in her vehicle at the end of her shift. CNA C stated, I saw [R4] pushing [R5] in the road . they hit a pothole, and I immediately parked my car and ran toward them. It looked like [R5] was either going to fall out of his chair or was going to try to stand up to navigate the pothole. On 7/24/24 at 3:15 PM, video footage of the elopement was reviewed by this surveyor with the Director of Nursing (DON). The following written timeline was provided to this surveyor: 18:12:00 [6:12:00 PM] - Residents left the building. 18:13:30 [6:12:30 PM] - [Employee, later identified as CNA D] shuts off door alarm. 18:19:00 - Residents return in [sic] to front door. On 7/25/24 at 1:00 PM, a phone interview was conducted with CNA D who verified she shut off the door alarm on 7/13/24 at the time of the elopement. CNA D stated, I should have used my CNA brain, but I didn't look around [for residents], I just shut it [the alarm] off . I had no education . I didn't know what residents were allowed in or out . when I was there, the alarm would go off constantly and somebody would just go and blindly shut it off [without checking for residents] . I was just shutting the alarm off because it was chaotic, and I didn't look around because everybody was doing it [shutting off the alarm without looking] throughout the day . On 7/25/24 at 2:15 PM, a follow-up interview was conducted with the DON who confirmed R4 and R5 were found in the road. The DON verified CNA D turned off the door alarm according to the video footage. When asked why it was reported to the SA that R4 and R5 were found on the facility sidewalk and the door alarm did not sound, the DON replied, I don't know. On 7/24/24 at 3:39 PM, an interview was conducted with Regional Director of Operations F who verified she was the author of the facility reported incident submitted to the SA. Regional Director of Operations F stated, I didn't do a good job explaining it [the elopement event] in the report. Regional Director of Operations F clarified R4 and R5 were initially spotted in the roadway, not on the facility sidewalk as originally reported. Regional Director of Operations F added, The first time I watched the video footage was yesterday [7/23/24] . I didn't think the alarm went off until I watched the video. I wasn't there [at the facility] when the investigation happened, I guess it was just an assumption [that the facility alarm did not sound]. On 7/24/24 at 4:17 PM, an email was received by Regional Director of Operations F that read, in part: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Please see attached 5 day [report] that was revised from my original 5 day that had non accurate information in it. Review of the revised incident summary read, in part: .residents [R5] and [R4] were outside where they exited on the sidewalk and rounded down the road left on [street name] . The door was held open by a visitor, the alarm was silenced by an employee . Review of facility policy titled, Incidents and Accidents Reporting, revised 8/11/22 read, in part: It is the policy of this facility for staff to use utilize electronic and/or approved forms to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident . The purpose of incident reporting is: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care . Meeting regulatory requirements for analysis and reporting of incidents and accidents . Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse prevention policy . The nurse/designee will enter the incident/accident information into the appropriate form/system within 24 hours of occurrent and will document all pertinent information . Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions . Review of facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/24 read, in part: .The facility will have written procedures that include: reporting of alleged violations to the Administrator, state agency .within specified timeframes as required by state and federal regulations . The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 Based on interview and record review, the facility failed to investigate an allegation of potential sexual abuse between two Residents (Residents #4 and #5) of nine residents reviewed for abuse. Findings include: Resident #4 (R4): Review of R4's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Alzheimer's Disease and diabetes. Record review of R4's most recent MDS assessment, dated 5/20/24, revealed a BIMS score of 7, indicative of severe cognitive impairment. Resident #5 (R5): Review of R5's EMR revealed admission to the facility on [DATE] with diagnoses including vascular dementia, congestive heart failure, and adjustment disorder with anxiety. Record review of R5's most recent MDS assessment, dated 5/20/24, revealed a BIMS score of 13, indicative of intact cognition. On 7/30/24 at 10:30 AM, a telephone interview was conducted with Certified Nursing Assistant (CNA) O regarding the protocol for reporting allegations of abuse. CNA O stated during a shift on 7/30/24 she walked into R5's room and observed him lying in bed with his pants pulled down and genitalia exposed. CNA O stated she observed R4 standing beside the bed. When asked if a sexual act was being performed, CNA O stated, I'm not entirely sure . I don't think so. R5 had a washcloth near so she may have been performing peri-care. When asked her next steps, CNA O stated she notified the floor nurse on duty, LPN A, and informed Regional Director of Clinical Services G by telephone. CNA O stated, I was really upset by the whole thing. Review of R4 and R5's EMR revealed no documentation of the event. On 7/30/24 at 12:12 PM, a telephone interview was conducted with LPN A who vaguely recalled the incident. LPN A stated that she informed the Director of Nursing (DON) but did not document the allegation. When asked why the incident was not documented, LPN A stated, The days are just too busy. I don't have time. I usually have around 29 residents to care for. On 7/30/24 at 11:40 AM, an interview was conducted with Regional Director of Clinical Services G who verified she received a call from CNA O on 7/14/24 with details regarding the incident between R4 and R5. Regional Director of Clinical Services G stated she informed CNA O to notify the abuse coordinator. When asked if she had any further involvement, Regional Director of Clinical Services G stated, It's a new building for me, so I don't know the residents. That why I told her [CNA O] to follow up with the abuse coordinator. When asked if there was any follow-up succeeding the allegation, Regional Director of Clinical Services G stated, There was a call, but I don't know what came of it. When asked it the incident should have been investigated, Regional Director of Clinical Services G stated, Yes. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at approximately 11:50 AM, an interview was conducted the Nursing Home Administrator (NHA) regarding his expectation on reporting allegations of sexual abuse. The NHA stated all allegations of abuse should be reported to him immediately. After a brief investigation, the NHA stated the allegation should be reported to the SA. When asked if the incident between R4 and R5 should have been investigated the NHA replied, Yes. Review of facility policy titled, Incidents and Accidents Reporting, revised 8/11/22 read, in part: .The nurse/designee will enter the incident/accident information into the appropriate form/system within 24 hours of occurrent and will document all pertinent information . Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Facility Reported Incident (FRI) MI00145815. Based on observation, interview, and record review, the facility failed to prevent, detect, and respond to an elopement resulting in the likelihood of serious harm, injury, impairment, or death for two Residents #4 and #5 (R4, R5) of three residents reviewed for elopement. Findings Include: The Immediate Jeopardy began on 7/13/24 at 6:18 PM when R4 and R5 eloped from the facility undetected and whose location was subsequently identified and reported to be on a thoroughfare by a facility visitor. Regional Director of Operations F was notified of the immediate jeopardy on 7/25/24 at 4:27 PM. At that time, a written plan of correction for removal was requested from the facility. This surveyor confirmed by interview and record review that the immediacy was removed on 7/25/24 at 5:45 PM, however, noncompliance remains at the potential for more than minimal harm due to sustained compliance which has not been verified by the State Agency (SA). Resident #4 (R4): Review of R4's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including Alzheimer's Disease and diabetes. Record review of R4's most recent Minimum Data Set (MDS) assessment, dated 5/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 7, indicative of severe cognitive impairment. Review of MDS Section GG, Functional Abilities and Goals, revealed R5 was unable to ambulate (walk) due to a medical condition or safety concern. Review of R4's plan of care revealed the following focus, initiated 5/17/24: Resident is at risk for elopement . with the following intervention: Resident wears Wanderguard; monitor placement/function. Resident #5 (R5): Review of R5's EMR revealed admission to the facility on [DATE] with diagnoses including vascular dementia, congestive heart failure, and adjustment disorder with anxiety. Record review of R5's most recent Minimum Data Set (MDS) assessment, dated 5/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicative of intact cognition. Review of R5's plan of care revealed the following focus, initiated 5/17/24: Resident is at risk for elopement . with the following intervention: Resident wears Wanderguard; monitor placement/function. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/23/24 at 11:15 AM, R4 was observed ambulating in the corridor outside her room with a staff member closely following. A wanderguard was observed on R4's left wrist. An interview was attempted and R4 was unable to answer questions related to the FRI. On 7/30/24 at approximately 12:40 PM, R4 was observed pushing R5 in a wheelchair throughout the facility corridors with a staff member closely following. A wanderguard was observed on R4 and R5's left and right wrists, respectively. Review of the FRI submitted to the SA included an incident summary which read, in part: .On 7/13/24, [R4] had assisted [R5] outside of the facility by a door held open by a visitor. Staff outside witnessed the residents and went to accompany them back into the facility. Another visitor saw them exit the facility and notified the nurses . Per the camera footage, residents [R5] and [R4] were outside on the sidewalk 7 minutes in which at that time they were accompanied inside the facility with staff . The wanderguard bracelets were removed per [R4], she took it off as they were annoying . The alarm did not go off in the facility as a visitor held the door open. Through investigation it was shown that this was not a true elopement as the visitor did open and hold the door open and the residents were wanting to go for a walk outside . This was not an elopement . On 7/23/24 at 1:07 PM, a phone interview was conducted with Licensed Practical Nurse (LPN) A who verified she was on duty at the time R4 and R5 eloped from the facility. LPN A stated she was standing at the nursing circle giving report to the oncoming nurse [Registered Nurse (RN) B] when a facility visitor approached her and RN B and notified them R4 and R5 were outside the facility. LPN A reported she and RN B ran outside and observed R4 pushing R5 in a wheelchair eastbound in a westbound lane on a roadway adjacent to the facility. When LPN A was asked if the door alarm sounded prior to R4 and R5's exit, she stated she couldn't recall as visitors were constantly coming in and out of the facility and the alarm sounds each time. LPN A stated, We don't have a receptionist. The alarm sounding has just become normal for us. When asked if R4 or R5 had a history of exit seeking behaviors, LPN A confirmed R5 attempted to exit the facility before. On 7/25/24 at 9:49 AM, a phone interview was conducted with RN B who confirmed she was receiving report from LPN A at the nurse's circle when a facility visitor approached them and stated, Do you know [R4 and R5] are outside? RN B stated she and LPN A immediately responded and, [R4 and R5] were nowhere to be found. RN B continued, We went to the end of the driveway and then to the left where there's an adjacent side road. RN B stated Certified Nursing Assistant (CNA) C was approaching R4 and R5 after spotting them when leaving work. RN B stated, I kept thinking to myself, how is this possible? They are supposed to have wanderguards. RN B stated after examination, neither R4 nor R5 were wearing wanderguards. On 7/24/24 at 2:41 PM, an interview was conducted with CNA C who confirmed she observed R4 pushing R5 in a wheelchair in the roadway when she was exiting the employee parking lot in her vehicle at the end of her shift. CNA C stated, I saw [R4] pushing [R5] in the road . they hit a pothole, and I immediately parked my car and ran toward them. It looked like [R5] was either going to fall out of his chair or was going to try to stand up to navigate the pothole. Review of R4's progress notes revealed the following entries: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. 5/16/24: .res [resident] started to leave the facility stating she could not stay here . When resident redirected, she gets upset and verbalizing of going home . Writer obtained wander guard order for elopement . 2. 5/17/24: ELOPEMENT: resident left front doors with writer + [and] Resident Advocate (RA) following. Writer +RA offering support, encouragement, reassurance but resident refusing to come back. Writer gave call out to staff at door to call the police . 3. 7/15/24: IDT [interdisciplinary team] met and reviewed resident related to recent elopement .Resident attempted elopement on the day she admitted to this facility but was able to be redirected and a wanderguard was placed, however resident did exit the facility the next day on 5/17/2024 with staff present . On the evening of 7/13 staff were alerted by a visitor that a resident was outside with another resident. Staff immediately responded and found them southeast of the front main entrance . their wander guards were removed. Staff were unable to locate the missing wander guards and it is unclear if this resident removed both wanderguards . On 7/24/24 at 3:15 PM, video footage of the elopement was reviewed by this surveyor with the Director of Nursing (DON). The following written timeline was provided to this surveyor: 18:12:00 [6:12:00 PM] - Residents left the building. 18:13:30 [6:12:30 PM] - [Employee, later identified as CNA D] shuts off door alarm. 18:19:00 - Residents return in [sic] to front door. On 7/25/24 at 1:00 PM, a phone interview was conducted with CNA D who verified she shut off the door alarm on 7/13/24 at the time of the elopement. CNA D stated, I should have used my CNA brain, but I didn't look around [for residents], I just shut it [the alarm] off . I had no education . I didn't know what residents were allowed in or out . when I was there, the alarm would go off constantly and somebody would just go and blindly shut it off [without checking for residents] . I was just shutting the alarm off because it was chaotic, and I didn't look around because everybody was doing it [shutting off the alarm without looking] throughout the day . On 7/25/24 at 2:15 PM, a follow-up interview was conducted with the DON who confirmed R4 and R5 were found in the road. The DON verified CNA D turned off the door alarm according to the video footage. When asked why it was reported to the SA that R4 and R5 were found on the facility sidewalk and the door alarm did not sound, the DON replied, I don't know. On 7/24/24 at 3:39 PM, an interview was conducted with Regional Director of Operations F who verified she was the author of the facility reported incident submitted to the SA. Regional Director of Operations F stated, I didn't do a good job explaining it [the elopement event] in the report. Regional Director of Operations F clarified R4 and R5 were initially spotted in the roadway, not on the facility sidewalk as originally reported. Regional Director of Operations F added, The first time I watched the video footage was yesterday [7/23/24] . I didn't think the alarm went off until I watched the video. I wasn't there [at the facility] when the investigation happened, I guess it was just an assumption [that the facility alarm did not sound]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/24/24 at 4:17 PM, an email was received by Regional Director of Operations F that read, in part: Please see attached 5 day [report] that was revised from my original 5 day that had non accurate information in it. Review of the revised incident summary read, in part: .residents [R5] and [R4] were outside where they exited on the sidewalk and rounded down the road left on [street name] . The door was held open by a visitor, the alarm was silenced by an employee . Review of Facility Policy titled Accidents and Supervision, revised 12/27/24 read, in part: .Identification of Hazards and Risks .all staff .are to be involved in observing and identifying potential hazards in the environment and the risk of a resident having an avoidable accident . implementation of interventions .this process includes .ensuring that the interventions are put into action .educating staff . monitoring and modification processes include .ensuring that interventions are implemented correctly and consistently .supervision is an intervention and a means of mitigating accident risk. The facility provides adequate supervision to prevent accidents . The Immediate Jeopardy which began on 7/13/24 was removed on 7/24/24 at 5:45 PM when the facility took the following actions to remove the immediacy. The Facility Removal Plan read: 1. Education was completed with all staff prior to their next shift worked regarding elopement risk and alarm fatigue. Any staff new at the facility will be educated prior to their shift regarding the residents at risk for elopement and orientation to the exit door and alarm. 2. A perimeter walk through was completed; all doors were noted to be secured. 3. Door codes were changed. 4. There is an employee stationed to monitor the front door from 8am-8pm with the door to be locked after to ensure safety until the front entry way is renovated to include a second set of doors alarmed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49302 This deficiency pertains to Complaint Intakes MI00145340 and MI00145457. Based on observation, interview and record review, the facility failed to provide sufficient staffing to address the care, needs, and safety of the entire facility population. This deficient practice resulted in unmet care needs and the potential for serious safety issues for all 69 residents of the facility. Findings include: Review of Complaint Intake MI00145457 submitted to the State Agency (SA) read, in part: .I am an RN [Registered Nurse N] . are we are currently understaffed. We have been understaffed for some time, but it has gotten to the point where it is unsafe for our residents . Last Friday [6/28/24] on night shift there was only 1 LPN [Licensed Practical Nurse] and 3 CNAs [Certified Nursing Assistants] in the building caring for 80 residents. Our DON [Director of Nursing] was aware of this and said she was coming in to help but then she stopped answering her phone and never showed up. Review of timecards from 6/28/24 - 6/29/24 revealed LPN P was the sole nurse on duty for 4.5 hours (2:00 AM - 6:30 AM) with a facility census of 77 residents. Review of the Facility Assessment, reviewed 11/24/22, revealed a staffing plan that indicated the total number of licensed nursing providing direct care on the midnight shift was 3. On 7/29/24 at 9:08 AM, a telephone interview was conducted with RN Q who reported ongoing concerns with understaffing, especially during the night shift. RN Q stated, Very frequently at night, one nurse is in charge of up to 45 residents . when it's brought up to management, it's brushed under the rug . Things are getting missed and not getting done . I have several reports of residents telling me how neglected they feel. When asked what care elements are being missed, RN Q indicated incontinence care, daily hygiene, and skin and wound treatments were frequently delayed. On 7/30/24 at approximately 9:15 AM, an interview was conducted with R9 on his perception of staffing levels. R9 stated he will frequently wait a week or more to receive a shower despite requests. R9 revealed staff will ask him to shower in early morning hours when other residents are sleeping due to staffing problems. R9 stated when he requests to receive assistance in the shower at a more appropriate time, staff generally charts that he refused. R9 stated, I've finally resorted to waiting until I stink so bad, they [facility staff] can't stand smelling me . There's more than one way to skin a cat. Review of R9's Shower/bathe task revealed he was offered 5 shower opportunities in a 30-day look-back window (7/3/24 to 7/30/24). R9 received a shower on 7/3/24, was documented as refusing a shower on 7/10/24, 7/23/24, and 7/26/24. On 7/30/24, R9's shower task was marked Not Applicable with no further explanation. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/30/24 at approximately 9:25 AM, an interview was conducted with R8 regarding staffing levels. R8 stated she frequently must wait 30 minutes or more for assistance after activating her call light. R8 indicated she frequently waits several hours during the night shift to receive assistance with incontinence care, requiring her to lay in a soiled brief for extended periods. R8 stated, There just isn't enough staff. On 7/30/24 at approximately 9:45 AM, an interview was conducted with R7 who stated she was admitted to the facility after a hip surgery and went an extended period without getting the surgical staples removed. Review of R9's orthopedic follow-up summary, dated 6/17/24 read, in part: .[R9] will follow-up in orthopedics in 6 weeks. Staples should be removed at [facility name] today [6/19/24] and Steri-Strips applied. Review of R9's progress notes, revealed the following entry on 7/1/24 by LPN J: Staples removed from right trochanter [hip area] . On 7/30/24 at 9:51 AM, an interview was conducted with LPN J regarding the 14-day delay in R9's staple removal. LPN J verified the delay and indicated it was due to both a communication error as well as low staffing. LPN J indicated that cares fall through the cracks due to inadequate staffing levels. On 7/30/24 at 11:40 AM, an interview was conducted with the Nursing Home Administrator (NHA), Regional Director of Clinical Services G, and Regional Director of Clinical Services H regarding staffing level concerns. Regional Director of Clinical Services H verified a ratio of 1 LPN to 77 resident residents for approximately 4. 5 hours from 6/28/24 - 6/29/24 and stated, It was unacceptable and not our standards. Regional Director of Clinical Services H did not know why the DON did not provide coverage despite the request. Review of facility policy titled, Quality of Care revised 1/1/22 read, in part: .each facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and plans of care .