STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235292	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Sault Ste Marie	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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 40383 Based on observation, interview, and record review the facility failed to ensure the contact information for the Office of the State Long-Term Care Ombudsman was posted in a form and manner accessible to residents and resident representatives. This deficient practice affected all 74 residents residing in the facility. Findings include: On 1/8/25 at 10:00 AM a confidential group meeting was held with eight residents. During the discussion, the residents stated they were unfamiliar with the Ombudsman and did not know how to contact the Office of the State Long-Term Care Ombudsman. After the meeting, the public postings were observed. The contact information for the ombudsman was not provided. During an interview on 1/8/25 at 1:30 PM, the Nursing Home Administrator (NHA) stated he did not see the ombudsman information posted. A policy for facility posting was requested. During an interview on 1/8/25 at 2:11 PM, the policy again was requested from the Assistant NHA B. There was not a policy for this procedure.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 13791 Based on observation, interview and record review the facility failed to provide a safe and sanitary environment for 6 of 6 residents of a total census of 74, who had personal refrigerators in their rooms. This deficient practice has the potential to result in personal food spoilage and contribute to an overall unsanitary condition in the rooms. Findings include: On 1/7/25 between 3:00 PM and 4:30 PM, resident rooms were observed for the presence of personal refrigerators. Six residents were identified having personal refrigerators which stored both perishable (lunch meats, dairy products, etc.) and non-perishable foods (canned beverages). Rooms identified with personal refrigerators were: A2; B7, B5, D9, D8, and D15. None of the six observed refrigerators were provided with a thermometer. Internal temperature measurements were made with an infrared thermometer which detected temperatures varying between 37 F and 54 F. No evidence of temperature logs were observed in proximity to the refrigerator units. On 1/8/25 at approximately 8:00 AM, a list of all residents having personal refrigerators in their rooms was requested from the Nursing Home Administrator (NHA) and assistant Administrator (AA) B. AA B stated We don't keep a list of those. NHA and AA B were requested to identify and produce a list of all residents in the facility who were keeping personal refrigerators in their rooms. At approximately 9:20 AM, the NHA provided a list of the residents the facility was aware of, who had personal refrigerators in their rooms. Only A8, B5, and B7 were identified by the facility, as those known to have refrigerators. When asked why three rooms were missed when identifying those with refrigerators, no response was forthcoming. On 1/7/25 at approximately 3:20 PM, a policy for the use of personal refrigerators in resident rooms was requested from the NHA. At approximately 3:55 PM, the policy was uploaded into the State Agency (SA) secured electronic document retrieval site. The policy named: Resident Refrigerators Revised on 01/01/2022 BY PHC, written and downloaded from The Compliance Store, LLC was reviewed. The policy provided by the facility included the following requirements to be followed when a personal refrigerator was used in a residents' room: 1. Dormitory-sized refrigerators are allowed when approved by the administrator prior to admission in a resident's room under the following conditions: a. The refrigerator is inspected by maintenance personnel and deemed safe prior to use and upon routine inspections. b. The refrigerator maintains proper temperatures. c. The electrical cord is without damage and the grounding prong is intact. d. Sufficient space exists in the resident's room to accommodate the refrigerator without requiring the use of extension cord or multi-plug adapter. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. The resident complies with the facility's policy for use of the refrigerator. 2. Housekeeping staff shall record refrigerator temperatures daily on a temperature log attached to the refrigerator. a. A thermometer shall remain in the refrigerator. b. Temperatures will be at or below 41 F, and freezers will be cold enough to keep foods frozen solid to the touch (or in accordance with state regulations). c. If temperatures are out of range, maintenance staff shall be notified. All foods that require refrigeration will be discarded immediately and remedies will be put into place. d. If problems persist with maintaining proper temperatures, the refrigerator shall be removed from use and the resident/family notified. 3. Housekeeping staff (or department assigned) shall clean the refrigerator daily and discard any foods that are out of compliance. Nursing staff shall clean up spills as needed or refer to housekeeping staff. 4. Residents and staff shall comply with safe food handling and storage principles: a. Perishable foods such as dairy products, meat, and processed foods made with perishable foods or eggs will be stored immediately upon receipt. b. Leftovers shall be dated upon receipt and discarded within three days. c. Foods with use-by dates shall be discarded accordingly. d. Any food with potential concerns (i.e. smell, packaging, appearance, frozen foods are not solid to touch) shall be discarded. e. Food shall be in covered containers or securely wrapped. f. Raw meat or eggs are not allowed in a resident's refrigerator. Processed meats in original containers are allowed (i.e. lunch meat). 5. Accommodations shall be made for the resident to be present for temperature checks. On 1/7/25 at approximately 4:10 PM, an interview with housekeeping supervisor (HS) A was conducted and asked if housekeeping staff monitored the temperature of residents' personal refrigerators. HS A stated We don't do that.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview, and record review, the facility failed to ensure care plans were updated promptly and revised appropriately for four Residents (R15, R24, R25, and R36) out of 18 Resident care plans reviewed. This deficient practice resulted in care plans which did not reflect resident needs. Findings include: Resident #15 (R15) On 11/5/24 a Facility Reported Incident (FRI) was submitted to the State Agency (SA) which read in part, Incident Summary: Resident #23 (R23) was witnessed yelling (obscenities) at resident (R15) staff immediately intervened and separated the 2 residents. The care plan for R15 included a Focus: Resident has impaired cognitive function related to disorganized thinking, Traumatic Brain Injury. Date Initiated: 08/03/2023. This care plan was updated 1/8/25 with an intervention to prevent further altercations which read, Make sure (initials of R23) is not seated close to resident (R15). Redirect resident by offering coffee or going for a walk when frustrated. During an interview on 1/9/25 at 10:44 AM, Certified Nurse Aide (CNA) V stated she worked throughout the building and knew R15. When asked to identify the resident with the initials listed in the care plan who should be seated further away from R15, CNA V named two residents with the care planned initials but was not sure who the care plan was referring to. During an interview on 1/9/25 at 10:47 AM, CNA W stated she worked with R15 at times and named one resident with the initials as stated in the care plan, but those initials were not of R23. During an interview on 1/9/25 at 10:50 AM, Nurse Aide (NA) Q stated she knew R15 but did not know who had the initials listed on the care plan for R15 to avoid. NA Q asked if the initials referred to a male or a female resident as she could think of one of each with the stated initials. Neither resident stated by NA Q were R23. During an interview on 1/9/25 at 1:16 PM, the Regional Clinical Registered Nurse (RN) K stated she had updated the care plan yesterday (1/8/25) and . did not update the care plan at the time (of the resident-to-resident altercation on 11/5/24). Resident #24 (R24) Review of R24's electronic medical record (EMR) indicated an initial admission to the facility on [DATE] with diagnoses including complete traumatic below the left knee amputation, diabetes and neuromuscular dysfunction of the bladder. During an interview on 1/8/25 at 8:42 AM, R24 stated he had been out to the hospital a few times due to his catheter and he continued to have a catheter for urinary elimination. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing progress notes for R24 on 11/30/2024 read in part, . Dr (name) called about resident continuous bleeding around foley cath (catheter) and blood collection in cath bag. Dr. (name) giving V.O. (verbal orders) to send resident and to contact family to help support resident needs. Resident brother (name) contacted and agrees he wants resident sent to ER (emergency room) . The care plan for R24 included a focus of alteration in elimination related to need for supra pubic catheter related to neurogenic bladder. Date initiated: 2/8/24 with the last revision 2/8/24. The goal for this care plan focus had been revised on 5/10/24, but the interventions had not been revised since 2/15/24. R24's care plan also included another focus of Resident has need for a suprapubic catheter. Date initiated 9/17/24 with all interventions dated as initiated 9/17/24. There were no intervention updates after the hospitalization on [DATE]. During an interview on 1/9/25 at 11:48 AM, Registered Nurse (RN) K stated she had reviewed the care plan for R24 and there was no updated care plan interventions to prevent dislodging of the catheter so that another hospital admission could be avoided. She stated the expectation was a care plan should be updated after a hospitalization to include interventions to prevent rehospitalization . Resident #25 (R25) Review of R25's EMR revealed admission to the facility on [DATE] with diagnoses including cerebral palsy, contractures, lack of coordination, and dementia. The most recent Minimum Data Set (MDS) assessment, dated 11/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 0, indicative of severe cognitive impairment. During a room visit on 1/7/25 at 12:47 PM, R25 was alert but non-verbal in bed grasping his TV remote with his clenched fists. He did not have any protective device such as a rolled cloth in his contracted closed fists to prevent skin breakdown. When asked if he could open his fists, he did not make eye contact or respond. During a room visit on 1/7/25 at 3:40 PM, R25 again was in bed gripping the TV remote and did not have any protective device such as a rolled cloth in his contracted closed fists to prevent skin breakdown. The care plan for R25 included a focus of Resident has pain related to contractures, cerebral palsy, dysthymic disorder (depressive disorder).Date Initiated: 08/11/2023 Revision on: 08/11/2023. Upon review of the care plan there were no interventions to prevent further decline of the contractures or to prevent negative outcomes due to the contractures. During an interview on 1/9/25 at 1:13 PM, the Director of Nursing (DON) revealed that she had reviewed the medical record and did not find anything in the care plan for services to prevent contractures or prevent further decline. The DON stated, I am not finding how to wash them (hand contractures) or care for them (hand contractures). It was her expectation that this would be part of the care plan. 45123 Resident 36 (R36) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R36's EMR revealed initial admission to the facility on [DATE] with diagnoses including dementia, hypertension, and cognitive communication deficit. Record review of R36's most recent Minimum Data Set (MDS) assessment, dated 9/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 01, indicative of severe cognitive impairment. Review of the FRI submitted to the State Agency (SA) included an incident summary dated 12/28/24, which read, in part: .[R36] was behind resident [Resident #50 (R50)] in the hall and reached up to grab resident [R50] on the shoulder, grabbing at his t-shirt and causing scratches to his right upper back and shoulder . Review of R36's Plan of Care revealed the following focus, initiated on 6/1/24: Resident has impaired communication .maintain eye contact, approach resident from the front, pay attention to resident's body language and facial expressions . On 1/8/25 at 3:55 PM, an interview was conducted with the Director of Nursing (DON) who was asked, if altercations between residents occur, what interventions take place to ensure residents are psychosocially stable and additional altercations do not occur. The DON replied, Social services will do an initial follow up with both residents and care plans are updated. The DON was asked if R36's care plan was updated and replied, Yes, and social services did the follow ups. The DON was asked to show where R36's care plan was updated and was unable to do so. The DON then acknowledged R36's care plan was never updated following the resident-to-resident altercation. The facility policy titled Comprehensive Care Plans dated as reviewed/revised 6/30/22, read in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Review of policy titled, Behavior Management Program, dated 10/27/23, read in part .Policy Explanation and Compliance Guidelines: 1.) Procedure .The team will explore the root cause of behavior/mood. The team will identify target behaviors and an individualized plan of care .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review the facility failed to provide appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one Resident (#25) of one resident reviewed for limited range of motion. This deficient practice had the potential for development and/or worsening of contractures, pain, and skin breakdown. Findings include: Resident #25 (R25) Review of R25's Electronic Medical Record (EMR) revealed admission to the facility on [DATE] with diagnoses including cerebral palsy, contractures, lack of coordination, and dementia. The most recent Minimum Data Set (MDS) assessment, dated 11/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 0, indicative of severe cognitive impairment. During a room visit on 1/7/25 at 12:47 PM, R25 was alert but non-verbal in bed grasping his TV remote with his clenched fists. He did not have any protective device such as a rolled cloth in his contracted closed fists to prevent skin breakdown. When asked if he could open his fists, he did not make eye contact or respond. During a room visit on 1/7/25 at 3:40 PM, R25 again was in bed gripping the TV remote and did not have any protective device such as a rolled cloth in his contracted closed fists to prevent skin breakdown. On 1/9/25 at 1:23 PM, Licensed Practical Nurse (LPN) X accompanied this surveyor to the room of R25 and confirmed R25 had contractures in both hands and did not have any interventions in place to prevent further decline. During an interview on 1/9/25 at 1:40 PM, the Director of Rehabilitation (DOR) (Staff) Y stated R25 was on case load and received treatment until 9/2/24 for contractures but had no treatment since that date. Staff Y stated she was just alerted R25 needed restorative therapy for his contractures. The care plan for R25 included a focus of Resident has pain related to contractures, cerebral palsy, dysthymic disorder (depressive disorder). Date Initiated: 08/11/2023 Revision on: 08/11/2023. Upon review of the care plan there were no interventions to prevent further decline of the contractures or to prevent negative outcomes due to the contractures. During an interview on 1/9/25 at 1:17 PM, Regional Clinical/Registered Nurse (RN) K stated the facility was working on putting a restorative program together and R25 was on the list to be included but it had not started. The facility provided a policy titled Restorative Nursing Programs dated as last reviewed/revised on 1/1/2022 which read in part: .The following types of residents could benefit from a Restorative Program(s) but not limited to: Contracture prevention and/or management .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 Based on observation, interview, and record review, the facility failed to appropriately store and label respiratory equipment, provide supplemental oxygen, and provide Continuous Positive Airway Pressure (CPAP) therapy according to physicians' orders for four Residents (#31, #46, #7, and #57) of four residents reviewed for respiratory care services. Findings include: Resident #31 (R31) On 1/7/25 at 11:50 a.m., R31 was observed wearing a nasal cannula (a tube used to deliver supplemental oxygen). The cannula tubing was observed dated 12/25/24. The oxygen concentrator was observed set to deliver 2.5 liters per minute (lpm) of supplemental oxygen. Physician's orders for R31 included an order for oxygen tubing/filter change every week to be changed by [name of oxygen supplier] weekly during rounds on Thursdays. Another physician's order for R31 read Oxygen: RUN @ [2]L (liters)/MIN (minute) VIA [X]N/C (nasal Cannula) . [X] CONTINUOUS. On 1/8/25 at 2:45 p.m., R31's O2 (oxygen) concentrator was set to deliver 3 lpm of supplemental O2. R31 said she did not know who changed the flow rate of oxygen. R31 said, It should be at two [LPM]. R31 had a respiratory care plan intervention for oxygen as ordered. Resident #46 (R46) On 1/7/25 at 12:53 p.m., a CPAP was observed atop the bedside stand in R46's room. The CPAP mask was not in a bag and did not have a barrier beneath it. The medical record of R46 did not contain a physician's order for the CPAP. There were no directions for care and maintenance of the CPAP on the Medication Administration Record (MAR), Treatment Administration Record (TAR), or elsewhere in R46's medical record. A progress note dated 9/13/24 at 11:49 a.m., read in part: .(R46) complained of CPAP mask not fitting properly. This writer provided (R46) with new CPAP mask and hose. Nurse was notified. Staff to assist with adjustment to ensure proper fit at HS [night] . There was no other documentation in the record mentioning the CPAP. On 1/9/25 at 12:55 p.m., Regional Nurse K said she could not definitively determine the length of time R46 had utilized a CPAP in the facility or when it was implemented for R46. Regional Nurse K confirmed the only notation of the CPAP in R46's medical record was the progress note on 9/13/24. No additional documentation could be located to determine if the CPAP mask and tubing had been changed since 9/13/24. No documentation was found regarding the CPAP settings, maintenance or instructions for use. Resident #7 (R7) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 8:20 a.m., a CPAP was observed atop the bedside stand in R7's room. The CPAP mask was not in a bag and did not have a barrier beneath it. A review of physician's orders on 1/9/25 did not reveal any orders for the CPAP. There was no care plan mentioning the CPAP. There were no directions for the care and maintenance of the CPAP on the MAR, TAR, or elsewhere in R7's medical record. The Director of Nursing (DON) was interviewed on 1/7/25 at 1:49 p.m. The DON confirmed physicians' orders are required for the use of supplemental oxygen and CPAPs. The DON said CPAP masks are expected to be cleaned daily and should be rinsed, allowed to air dry on paper towels, then placed in a bag when not in use. The DON said oxygen tubing should be changed and dated weekly. During a follow-up interview on 1/9/25 at 10:28 a.m., the DON said the facility did not have standing orders for supplemental oxygen or parameters when flow rates for supplemental oxygen delivery would be adjusted. The DON said supplemental oxygen is expected to be delivered at the rate set in a physician's order. The policy CPAP/BiPAP (Bilevel Positive Airway Pressure)/NIPPV (Non-Invasive Positive Pressure Ventilation) Support dated 1/1/21 read, in part: .Review the physician's order to determine the oxygen concentration or liter flow, and the pressure (CPAP, IPAP and EPAP) for the machine .Documentation 1. General assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure; 2. Time NIPPV was started; duration of the therapy; 3. Mode and settings for the CPAP/BiPAP; . 45123 Resident #57 (R57) Review of R57's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including lung cancer, pneumonia, and anxiety. Record review of R57's most recent Minimum Data Set (MDS) assessment, dated 10/31/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicative of intact cognition. On 1/7/25 at 11:30 AM, an observation was made of R57 lying in her bed with a nasal cannula (soft plastic tubing to infuse oxygen through the nose) on, infusing 10 liters of oxygen via oxygen concentrator. R57's oxygen concentrator was connected to a bubbler (a container that holds water to emit humidified oxygen through a nasal cannula). R57's bubbler reservoir was observed empty. R57 was asked if they were aware that their bubbler was empty replied, No, is that why my nose is so dry? On 1/7/25 at 4:30 PM, an observation was made of R57's oxygen concentrator bubbler and the reservoir remained empty with a date of 1/2/25 on the outside. R57 had a gallon container of water next to their oxygen concentrator on the floor to the right of the machine. On 1/7/25 at 4:05 PM, an interview was conducted with Licensed Practical Nurse (LPN) E who was asked if R57's bubbler should be empty and replied, No, I will go and check it out. Review of R57's physician order summary, dated 4/26/24 through 1/7/25, revealed no orders for oxygen, use/maintenance of an oxygen humidifier (bubbler), or for changing the oxygen tubing/filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Hospice visit notes, dated 4/20/24 through 12/31/24, revealed R57 had been utilizing 5 to 10 liters of oxygen since her admission. Review of Hospice Plan of Care Update Report, dated 12/16/24, revealed an oxygen recommendation order for R57 for 2 to 5 liters as needed with an original date of 4/20/24. Review of R57's Plan of Care revealed the following focus, initiated on 4/29/24: Resident has an impaired pulmonary/respiratory status .Oxygen as ordered . On 1/7/25 at 4:15 PM, an interview was conducted with Regional Clinical Nurse K who was asked if R57 had an oxygen order and how long R57 had been utilizing oxygen and stated, R57 has been on oxygen since their admission to the facility. I do not see an oxygen order and there should be one. Regional Clinical Nurse K was asked if R57 had a high flow nasal cannula to deliver the high flow rate of 10 liters and replied, I am not sure, but I will ask the oxygen company if that is necessary for the high flow. Review of the facility policy titled, Oxygen Administration, dated 10/26/23, read in part Policy: Oxygen is administered to resident who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences .Policy Explanation and Compliance Guidelines: 1.) Oxygen is administered under orders of a physician .Other infection control measure include . c. Change humidifier bottle when empty, every 72 hours, or as recommended by the manufacturer .11.) Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397 Based on interview, and record review the facility failed to maintain sufficient nursing staff as evidenced by confidential resident and family interviews and payroll data analysis. This deficient practice resulted in embarrassment and worry on the part of residents whose needs were not met with potential to impact all 74 residents living in the facility. Findings include: A review of the Payroll-Based Journal (PBJ) report indicated excessively low staffing levels and a one star staffing rating in the fourth quarter (July1-September 30). A review of the facility's Facility Assessment Tool for Medilodge of [NAME] Ste. [NAME] 08/2023 through 07/2024 indicated Each hall is staffed based on resident acuity. Resident acuity is discussed each morning at the IDT (Interdisciplinary Team) morning meeting. IDT discusses current resident acuity on each unit, admission planned for the next 48 hours and discharges planned for the next 48 hours. Staffing levels are adjusted based on the evaluation of acuity. The charge nurse may adjusted (sic) staffing levels and assignments at any time based on the acuity of the residents residing in the facility Day shift 6-7 CNA's (Certified Nursing Assistants) 3 nurses Afternoon shift 6-7 CNA's 2-3 nurses Night shift 4-5 CNA's 2-3 nurses A review of the staffing list from 8/10/24 indicated four CNAs were scheduled with one CNA indicated as no call no show for the day shift. Leaving just three CNAs to work the four halls. The night shift only had three CNAs scheduled to work the four halls. A review of the staffing list from 8/11/24 indicated five CNAs were scheduled for the day shift with one no call no show and one WNBI (Will Not Be In) leaving three to work the four halls. The night shift had three CNAs scheduled with one WNBI. Leaving two CNAs scheduled to work the four halls. A review of the staffing list from 8/25/24 indicated four CNAs were scheduled for the day shift, with a fifth CNA noted to work 8a-12p to work the four halls. Notations at the bottom stated carry over 2X CNA from night shift 6a-10a. There was no indication to specify which day the two night shift CNA's were to be carried over, nor if they carried any CNA's over. A review of the staffing list from 9/14/24 indicated two CNAs were scheduled with a third covering 6a-10a and fourth CNA coming in at 10a-6p. This allowed for three CNAs for the entire day shift. 8/10/24, 8/11/24, 8/25/24, and 9/14/24 do not follow the facility assessment's staffing requirements. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	While conducting an interview on 1/9/25 at 12:25 PM, CNA O stated the facility was short staffed 85% of the time, especially on weekends. CNA O stated that there was extra help on 1/9/25 as the facility offered monetary incentive to staff to help cover while state was here. CNA O stated monetary incentives were not typically offered to help cover shifts when they were short staffed. CNA O stated three CNAs were scheduled on the floor 1/9/25 when there are normally six to seven. CNA O stated they were a bit shorter due to the COVID outbreak, but didn't feel this was too unusual. Staffing during these periods fell below the facility's established minimum staffing plan and did not adequately account for resident acuity or care needs. 40383 On 1/8/25 at 10:06 AM, a confidential group meeting was held with eight residents who wished to remain anonymous. The topic of staffing and resident care was discussed. One Resident (C1) stated there were not enough staff to meet the needs of the residents and felt they often had to wait too long after using the call light. When asked if they had experienced any specific problems, C1 expressed frustration and replied, Sometimes you have no choice but to go in your pants. During an interview on 1/7/25 at approximately 12:40 PM, confidential family member (FM) T was noted to have the call light on for her mother to use the bathroom. FM T stated it had been on for some time and no one had answered it yet. The call light was answered at 12:47 PM, but the staff member had to leave to get another staff member to assist. FM T said the facility was short staffed and stated her mother was in the same clothes for four days. FM T said her mom had experienced a stomachache the night before and no one had ever come. During an interview on 1/7/25 at 2:48 PM, family member (FM) U stated R178 had to wait over an hour for care and worried that he might poop his pants. .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49397 Based on interview and record review, the facility failed to reflect the actual hours worked by nursing staff (nurses and certified nursing assistants), this has the potential to affect all 74 residents within the facility. This deficient practice resulted in necessary staffing information not being available to residents and visitors. Findings include: A record review was conducted of the facility's daily staffing positing dated 1/7/25, 1/8/25, 1/9/25 revealed the hours and numbers of the licensed staff, Registered Nurses (RN), Licensed Practical Nurses (LPN), and non-licensed staff (CNA (sic) Certified Nursing Assistants) for day and night shifts. The posting indicated it was to be posted 2 hours prior to shift start. There was no indication of actual hours worked on the sheet for the day and night shifts. While conducting an interview on 1/9/25 at approximately 9:33 AM, the DON showed the daily staffing posting, stating that it included all staff present with hours worked in facility. The DON stated they had a nurse that was to cover that morning that did not come in due to illness. The daily staffing posting did not indicate hours adjusted from the nurse who called in for licensed staff.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on interview and record review, the facility failed to provide adequate medically related social services for one Resident (R36) of four residents reviewed for social services care. Findings include: Resident 36 (R36) Review of R36's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia, hypertension, and cognitive communication deficit. Record review of R36's most recent Minimum Data Set (MDS) assessment, dated 9/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 1, indicative of severe cognitive impairment. Review of the Facility Reported Incident (FRI) submitted to the State Agency (SA) dated 12/28/24 included an incident summary which read, in part: .[R36] was behind resident [Resident #50 (R50)] in the hall and reached up to grab resident [R50] on the shoulder, grabbing at his t-shirt and causing scratches to his right upper back and shoulder . Review of R36's Plan of Care revealed the following focus, initiated on 6/1/24: Resident has impaired communication . maintain eye contact, approach resident from the front, pay attention to resident's body language and facial expressions . According to the facility incident report, dated 12/28/24, read in part [R50] was exiting the dining room and was grabbed by another resident [R36]. [R50] has scratch on right back and a pinch mark on his right forearm. 'Someone grabbed and twisted my arm, and I don't know why they did that to me . Review of R36's progress note, dated 12/28/24, read in part [R50] exiting dining room in his w/c (wheelchair) self-ambulating. Another resident [R36] exiting at the same time and bumping into resident [R50]. [R50] becoming aggressive to other (sic) resident [R36], physically grabbing . [R36] by his t-shirt collar and pulling . Review of R36's interdisciplinary progress note, dated 12/31/24, read in part .requested medication review of pharmacist r/t (related to) resident reaching up and then scratching another resident in a congested area. This resident is nonverbal . On 1/8/25 at 3:55 PM, an interview was conducted with the Director of Nursing (DON) who was asked if altercations between residents occurred what interventions were put in place to ensure residents were psychosocially stable and additional altercations do not occur. The DON replied, Social services will do an initial follow up with both residents and care plans are updated. The DON was asked if R36's care plan was updated and replied, Yes, and social services did the follow ups. The DON was asked to show where R36's care plan was updated and was unable to as R36's care plan was never updated following the resident-to-resident altercation. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 4:05 PM, an interview was conduced with Social Services Director P who was asked if she spoke with R36 after the incident on 12/28/24 and replied, I should have. If I did, I would have made a progress note regarding it. Social Services Director P was asked if she could look for a progress note and provide it to this Surveyor. Social Service Director was unable to produce documentation by the end of the survey that supported they had provided adequate medically related social services to R36. Social Services Director was unable to produce requested documentation by the end of the survey. Review of policy titled, Behavior Management Program, dated 10/27/23, read in part .Policy Explanation and Compliance Guidelines: 1.) Procedure .The team will explore the root cause of behavior/mood. The team will identify target behaviors and an individualized plan of care .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review the facility failed to ensure their medication error rate was below 5% when three medication errors were observed from a total of 26 opportunities for one Resident (#7) of two residents reviewed for medication administration. This deficient practice resulted in a medication error rate of 11.54%. Findings include: Resident 7 (R7) Review of the medical record revealed R7 admitted to the facility on [DATE] with diagnoses including diabetes mellitus, heart disease, sleep apnea, and hypertension. Record review of R7's most recent Minimum Data Set (MDS) assessment, dated 12/7/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. On 1/9/25 at 8:20 AM, Registered Nurse (RN) C was observed preparing and administering medications to R7. RN C prepared two insulin glargine pens, one with 9 units and the other with 16 units to total a total of 25 units. RN C also prepared an insulin needle for R7 with 4 units of insulin lispro and a carvedilol (blood bressure medication) 6.25 mg (milligrams) oral tablet. RN C administered the insulins to R7 holding each site for only two seconds. R7's skin at all three injections sites post injection was observed to have a clear liquid leaking from the sites. RN C checked R7's blood pressure at 105/50 and pulse at 81 and administered the carvedilol. Review of R7's Medication Administration Record (MAR), dated January 2025, revealed an order for carvedilol 6.25 mg, give one tablet by mouth every morning and at bedtime for HNT (hypertension). Hold for SBP (systolic blood pressure) less than 120 or diastolic BP (blood pressure) less than 50, and with start date of 12/17/24. On 1/9/25 at 9:00 AM, an interview was conducted with RN C who was asked if she was aware R7 had blood pressure parameters for the carvedilol and replied, I took R7's blood pressure and pulse. RN C was asked to review the order and replied, I don't know why the computer system allowed me to give the medication if the blood pressure was not in the range. I better call the doctor and make them aware and recheck (R7's) blood pressure and pulse in a little while. Review of How to Use Your Insulin Glargine Pen revealed: Step 5. Inject Your Dose: Use your thumb to press the injection button all the way down. When the number in the dose window returns to zero as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.) Review of Instructions for Use Insulin Lispro Injection via Vial and Needle: Step 11: Push down on the plunger to inject your dose. The needle should stay in your skin for at least 5 seconds to make sure you have injected all of your insulin dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN C when providing a medication pass for R7 resulted in three total errors, including two for not holding the insulin pen needle in in place for the recommended time to ensure proper delivery for each insuin type, and one for administering the carvedilol outside of the parameters for administration. On 1/9/25 at 9:10 AM, an interview was conducted with Regional Clinical Nurse K who asked how RN C did with their medication pass and was made aware of the errors RN C had made and replied, Oh, well they normally do not work the floor. I will follow up with them and educate. Review of the facility policy titled Medication Administration, dated 1/1/22, read in part, Policy: Medications are administered . as ordered by the physician and in accordance with professional standards of practice . Policy Explanation and Compliance Guidelines .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters .14. Administer medication as ordered in accordance with manufacturer specifications .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45123 Based on observation, interview, and record review, the facility failed to: 1. Secure one topical medication, 2. Securely lock a treatment cart and, 3. Store medications properly for one of two medication carts reviewed for medication storage. This deficient practice had the potential for medication errors, drug diversion, and ingestion of medications inappropriate for consumption for cognitively impaired residents. Findings include: On 1/7/25 at 11:58 AM, an observation was made of an unlocked and unattended treatment cart on the A-hall. This Surveyor opened the treatment cart which contained eight topical medication creams and various wound care supplies. One of the wound care supplies normal saline 500 ml (milliliters) was opened with approximately 300 ml of liquid and had no date to show when it was opened. On 1/7/25 at 12:07 PM, an observation was made of R21 in her room. R21 was sitting in her wheelchair. During an observation of R21's bathroom a topical medication cream identified as Nystat (Nystatin [topical antifungal agent] was observed sitting on a ledge. Review of R21's physician order, dated 10/23/24, revealed an order for Nystat External Cream 100000 unit/GM (gram), apply to groin topically every morning and at bedtime for redness. Review of R21's Quarterly Nursing Assessment, dated 11/15/24, revealed in Section O. Medications, Question 1. Self-Administration of Medications - Does not wish to self-administer medications. On 1/7/25 at 2:15 PM, an interview was conducted with Licensed Practical Nurse (LPN) E who was asked about cognitively impaired and wandering residents on the A-hall unit and the medication treatment cart and replied, Yes, there are cognitively impaired residents on the A-hall unit and the medication treatment cart should be locked unless attended. On 1/8/25 at 8:05 AM, an observation was made of the D-hall medication cart and the following was observed: a.) One medication cup of crushed medications in the top drawer, unlabeled for an unidentified resident, b.) One white, round pill loose in the second drawer and identified as escitalopram (antidepressant) 10 mg, c.) One white, oblong pill (with identifiers as TEVA and 22/10) loose in draw two and identified as sucralfate (medication for stomach ulcers) 1000 mg, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d.) A 20 oz (ounce) water bottle with a red substance identified as the floor nurse's beverage, stored in the bottom drawer of the medication cart, e.) One orange round pill (with identifier 30) loose in the second drawer and identified as nifedipine (blood pressure medication) extended release 30 mg and, f.) One round yellow (with identifier P) loose in the second drawer and identified as aspirin 81 mg enteric coated Review of policy titled, Medication Storage, dated 1/30/24, read in part Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guideline: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments .

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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. 49310 Based on observation, interview, and record review, the facility failed to ensure effective infection control practices and the appropriate use of personal protective equipment (PPE) for two Residents (#9 and #38) of seven residents reviewed for infection prevention and control. This deficient practice resulted in the potential transmission of communicable disease and infectious organisms to all 74 residents residing in the facility. Findings include: Resident #38 (R38) On 1/7/25 at approximately 11:35 a.m., R38's room was observed with three signs posted on the door indicating isolation for contact precautions, airborne precautions, and droplet precautions. The door to the room was open, and two residents were observed in the room (R38 and R38's room mate). The sign for airborne precautions read, in part: .Door to room must remain closed . There was no indication on the signage indicating which isolation precaution pertained to which resident. Resident #9 (R9) At approximately 11: 38 a.m. on 1/7/25, R9's room was noted to have four signs posted on the door indicating isolation for contact precautions, airborne precautions, enhanced barrier precautions (EBP), and droplet precautions. The door to the room was open and two residents were noted in the room (R9 and R9's roommate). The sign for airborne precautions read, in part: .Door to room must remain closed . There was no indication on the signage indicating which isolation precaution pertained to which resident. On 1/7/25 at approximately 11:40 a.m., Certified Nurse Aide (CNA) D said the two residents residing in R38's room and the two residents residing in R9's room had COVID-19. CNA D confirmed she was assigned on 1/7/25 to the D-hall where R38 and R9 resided. CNA D said she was not usually assigned to the D-hall and was unfamiliar with the residents, but she was working with Licensed Practical Nurse (LPN) F and CNA Q who were familiar with the residents. During an interview on 1/7/25 at 12:11 p.m., LPN F said there were two residents on D-hall who had COVID-19: R38 and R9. LPN F was asked how staff who do not routinely work on the D-hall or newly hired staff would know which resident in each room had COVID-19. LPN F responded, That's a good question . the CNA's wouldn't know unless a nurse told them. LPN F confirmed he had not provided information regarding residents who had COVID-19 to CNA D and did not provide CNA D with any instructions regarding PPE or isolation precautions for R38 and R9. On 1/7/25 at 1:45 p.m., CNA Q was asked why the door to R9's room had EBP signage. CNA Q responded, Because the resident has COVID. When asked why an EBP sign wasn't posted on the door to R38's room that also housed a resident with COVID-19, CNA Q responded, There should be a sign - it must have fell off. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) and Regional Nurse K were interviewed on 1/7/25 at 1:49 p.m. When asked why EBP is posted on the door of R9's room, the Regional Nurse said the roommate of R9 was on EBP due to hemodialysis. When asked if residents with COVID-19 were on EBP the DON said, No. That's something else entirely. When told CNA Q said residents with COVID-19 were on EBP, the DON said, I'll educate them. When asked how staff would know which resident was in which precautions the DON said, We'll need to perfect that process and did not provide an answer for how staff would know about the precautions. The DON was asked why airborne precautions signage was posted on doors of residents with COVID-19. The DON said, The airborne precautions sign is only there to direct the staff to keep the door to the room shut. When told the doors to R38's room and R9's room were observed open the DON said, The goal is to have the door closed. The door should be closed. The DON said some residents need the door to the room open for supervision, and indicated the plans of care would contain information if a door needed to be open for increased monitoring or medical necessity. The care plans for R38 and R38's roommate were reviewed on 1/7/25 at approximately 2:05 p.m. The care plans did not include interventions to keep the door to the room open. The care plans for R9 and R9's roommate were reviewed on 1/7/25 at approximately 2:10 p.m. The care plans did not include interventions to keep the door to the room open. The door to R38's room was observed open on 1/7/25 at 11:35 a.m., 1/7/25 at 12:56 p.m., 1/7/25 at 1:45 p.m. , 1/8/25 at 7:50 a.m., 1/8/25 at 9:01 a.m., 1/8/25 at 9:34 a.m., 1/8/24 at 12:35 p.m., and 1/9/25 at 7:45 a.m. The door to R9's room was observed open on 1/7/25 at 11:38 a.m., 1/7/25 at 1:45 a.m., 1/8/25 at 9:01 a.m., 1/8/25 at 9:34 a.m., 1/8/25 at 10:13 a.m., and 1/9/25 at 7:47 a.m. On 1/8/25 at 9:34 a.m., CNA S was asked if PPE was available in the rooms of residents on transmission-based precautions. CNA S said, No - all the PPE is kept in the carts outside the doors in the hallway. On 1/8/25 at 1:00 p.m., CNA S took the meal tray for R38 from the tray cart to R38's room. CNA S placed the meal tray on an isolation cart containing PPE. The tray was placed atop a pink, plastic bin labeled dirty that contained a face shield. After donning PPE from the isolation cart, CNA S picked up the tray from atop the plastic bin and entered R38's room. CNA S set the tray on R38's over bed table and assisted R38 with meal set up. CNA S left R38's bedside and went to the doorway of the room where CNA D provided CNA S with the meal tray for R38's roommate. CNA S took the tray to R38's roommate and assisted the resident with meal set-up without changing PPE. CNA D was asked why the pink plastic bin containing a face shield was labeled dirty. CNA D said the face shield had been worn in R38's room but had not yet been sanitized. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy COVID-19 Prevention, Response and Reporting dated as last reviewed/revised on 5/26/24 read, in part: .It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 .The facility will establish a process to identify and manage individuals with suspected or confirmed SARS-CoV-2 infection . residents, however, should not be cohorted with residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing . Residents with suspected or confirmed SARS-CoV-2 infection should be placed in a single-person room when possible and available with the door kept closed . If cohorting, only residents with the same respiratory pathogen should be housed in the same room . On 1/7/25 at 10:50 a.m., a clear plastic garbage bag filled with refuse was observed on the floor in the A-hall outside a door with posted isolation signage. Housekeeper R (HKP R) was in the open doorway of the room wearing a gown, gloves, N95 mask, and face shield. HKP R said the resident in the room with isolation signage had COVID-19 and said she placed the bag on the floor to throw away when she was finished cleaning the room. On 1/8/25 at 2:12 p.m., HKP R exited a room on A-hall where a resident with COVID-19 resided and walked down and across the hallway to the housekeeping cart wearing a gown, gloves, N95 mask, and a face shield. HKP R was asked why she was wearing PPE in the hallway. HKP R pointed to the room she had exited and said, The resident in that room has COVID and we wear all the equipment. I'm still working in there. I just had to get some things from my cart. On 1/9/25 at 10:28 a.m., the DON was asked about placing garbage bags on the floor in the hallway. The DON said refuse bags were to be placed in the larger garbage containers for disposal and confirmed garbage bags should never be placed directly on the floor. The DON said, That is not our policy or practice. On 1/9/25 at 1:22 p.m., the DON was asked about the staff exiting rooms of residents in transmission-based precautions wearing PPE that had been worn inside the room. The DON said, They're following the instructions on the outside of the door to wear the PPE, but they're not following the instructions posted on the inside of the door to remove PPE before exiting. The DON confirmed PPE should not be worn from a resident's room into the hallway, and said the expectation is to remove PPE prior to exiting a resident's room. The policy Transmission-Based (Isolation) Precautions dated as last reviewed/revised on 12/27/23 read, in part: .It is our policy to take appropriate precautions to prevent transmission of pathogens .Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens . The Centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2 guidelines found at: www.cdc.gov/covid/hcp/infection-control/?CDC states, in part: .Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection . The door should be kept closed (if safe to do so) .