STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Farmington	34225 Grand River Ave Farmington, MI 48335

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00148587. Based on observation, interview and record reviews the facility failed to treat the resident with respect/dignity and ensure to honor their rights per the facility policy, for one (R306) of one resident reviewed for dignity and respect. Findings include: On 2/4/25 at 11:19 AM, R306 was observed lying on their back in bed. When asked about their stay at the facility R306 stated in part, . The new administrator came on Friday and said I need to get it (refrigerator) out of here. It was rude and why all of a sudden when the prior Administrator approved it? I feel like they treat me differently maliciously and why? It really isn't necessary . she rudely said she will take my refrigerator out of here . I had this refrigerator for more than a year here . The resident went on to verbalize how they were a chef for over [AGE] years and maintained their refrigerator by ensuring the food containers were dated and the refrigerator was kept clean. A review of the medical record revealed R306 was admitted to the facility on [DATE] with diagnoses that included: chronic kidney disease, cardiac pacemaker, anxiety disorder and major depressive disorder. On 2/5/25 at 3:51 PM, a follow up interview was conducted with R306. R306 was observed lying on their back in bed. R306 stated the new Administrator told them they could not have their refrigerator due to State policy and law. R306's refrigerator was observed packed into a box in their room. On 2/5/25 at 2:13 PM, the Administrator was asked to provide the facility's policy on residents having personal refrigerators in the facility. A review of a facility policy titled Resident Refrigerators revised 01/01/2022, documented . it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators when approved by the administrator for use in the facility . Dormitory-sized refrigerators are allowed when approved by the administrator prior to admission in a resident's room . Housekeeping staff (or department assigned) shall clean the refrigerator daily . Nursing staff shall clean up spills as needed . (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 4:27 PM, the Administrator was interviewed. In attendance were several corporate staff members. The Administrator was asked if they informed R306 that they could no longer have a refrigerator in their room and the Administrator confirmed they had. The Administrator was asked why R306 was unable to have their refrigerator and the Administrator replied their previous facility they were employed at did not allow residents to have their own refrigerator. The Administrator was asked if they reviewed the policy of their current facility which documented that a resident could have a refrigerator from the approval of the Administrator, which R306's refrigerator was approved by the facility's previous Administrator. The Administrator stated they did not review the policy. The Administrator then stated R306's refrigerator was not the correct measurements and the resident could not keep it clean because they required assistance from the staff. The Administrator was reminded that R306's refrigerator was already approved by the previous Administrator which they had for over a year already in the facility and per the facility policy, staff are the personnel designated to clean and maintain the resident's refrigerator. The Administrator was asked if they had adequate staff within the facility to ensure R306's refrigerator was maintained and cleaned? No response was provided. The Administrator was asked to clarify the reason for the removal of R306's refrigerator, was it their belief that refrigerators were not allowed in the facility, the measurement of the refrigerator or the inability of the resident to maintain and clean the refrigerator. In response the Regional Director of Operations (RDO) G stated they will review the policy and change it if needed. RDO G was asked after they reviewed and modified the policy, to inform the surveyor of the ending results. No further explanation or documentation was provided by the end of the survey.

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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. 32568 This citation pertains to Intake Number(s): MI00149629, MI00149425, and MI00149174. Based on observation, interview, and record review, the facility failed to ensure there was an adequate supply of linens for three (R300, R301, and R305) of three residents reviewed for linens and the potential to affect all residents on the second floor. Findings include: A review of a complaint submitted to the State Survey Agency (SSA) revealed an allegation that the facility was short on wash cloths and that they were stained with feces. A review of a second complaint to the SSA revealed an allegation that the facility ran out of clean towels and wash cloths on a regular basis. In addition, it was alleged there was a limited number of blankets and they were not washed regularly. A review of a third complaint submitted to the SSA revealed an allegation that the facility is always short on linens. R300 On 2/4/25 at approximately 12:00 PM, an interview was conducted with R300's family member who reported a concern about the facility switching from using wipes to washcloths to clean residents up. According to R300's family member, the facility often ran out of towels and washcloths since they made that change. R300 reported being asked by management to fill out a concern form regarding that issue. A review of a Quality Assistance Form dated 1/8/24 that indicated R300's family member brought the following concern to the Director of Nursing's (DON) attention: Today towel was brought in the room that was dingy from being used on changing someone with bowels, wipes (are) needed its unsanitary, water does not get hot enough to clean the linen especially with patients having wounds. There are shortage of linens to even provide care. The concern was assigned to the former Administrator, Administrator 'M'. The sections for Findings, Plan/Actions, and whether the concern was resolved was left blank. R301 On 2/4/25 at 1:56 PM, R301's family member indicated via e-mail communication that the facility frequently ran out of washcloths and they had to purchase their own. R301's family member reported R301 required to be cleaned up frequently due to secretions that came out of their tracheostomy tube (tube inserted into the windpipe to assist with breathing). 34275 R305 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at approximately 10:56 AM, an interview was conducted with Certified Nursing Assistant (CNA) W. When asked if the facility provided enough supplies to clean and wash the residents, CNA W reported that the facility no longer provides wipes to clean the residents and they currently use washcloths. When asked if the facility provided enough washcloths, CNA W stated No. CNA W then escorted the Surveyor to the linen storage closet(s) on the 2nd floor. There were no wash clothes observed in linen closet. An observation was then conducted on the first floor. In the linen storage room on the [NAME] Hall (1st floor) there were approximately 10 washcloths. The linen room on the East Hall (1st floor) did not have any washcloths. On 2/6/25 at approximately 10:30 AM, R305 was observed lying in bed. The resident was alert and able to answer all questions provided. R305 was asked if the facility provided enough linen to provide care, the resident stated No. They then pointed to a large towel at the end of their bed and noted I rarely get a washcloth to clean myself and they are no longer providing wipes. 48680 On 2/6/25 at 8:35 AM an observation of two of four of the facility's linen closets and laundry room was made with the Director of Nursing (DON) and the Administrator. Further observations revealed that the linen closet on the second floor had a few face towels, three big towels, a couple of fitted sheets, no flat sheets or gowns. The DON was asked was this considered enough supplies for staff to efficiently complete their job. The DON reported no, but explained there was available linen in the laundry room that staff could use. On 2/6/25 at 8:49 AM an observation of the facility's laundry room was made. The laundry room had two clean linen carts. Neither linen cart had linen on them. The Administrator asked House Keeping Manager DD was the linen on the units all that staff have access too at this time. The House keeping manager DD reported yes and explained that the laundry room had a leak, and a washer machine was down. There was no additional information provided by exit of survey.

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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** 32568 This citation pertains to Intake Number(s): MI00149262. Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the State Agency within the required time frame for one (R303) of three residents reviewed for abuse. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Survey Agency (SSA) on 12/13/24 revealed an allegation was made by R303 that Certified Nursing Assistant (CNA) 'H' was rough with her while providing peri-care. On 2/4/25 at 10:15 AM, the Administrator was asked to provide the facility's investigation into the above alleged incident. A review of the investigation revealed, Administrator 'M' was first notified of R303's allegation against CNA 'H' on 12/11/24. According to the incident report submitted to the SSA, the allegation was not reported to SSA until 12/13/24. On 2/6/25 at 1:00 PM, R303 was observed lying in bed. R303 did not appear to be able to move in bed independently. When interviewed, R303 reported she required assistance from staff to reposition in bed and staff assisted with brief changes. When queried about what occurred with CNA 'H', R303 reported CNA 'H' was assigned to her, checked on her every two hours to see if she needed a brief change, and during his last rounds, R303 needed a brief change. R303 reported CNA 'H' started to changed her brief and grabbed my vagina roughly. R303 denied that it was sexual in nature, but said it was mean. R303 reported the incident to Licensed Practical Nurse (LPN) 'L'. R303 explained Administrator 'M' (who was no longer employed at the facility) came to talk with her and CNA 'H' did not provide care for her any longer but still worked at the facility. A review of R303's clinical record revealed R303's was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: rheumatoid arthritis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R303's had intact cognition and was dependent on staff assistance for bed mobility, and toilet hygiene. A review of R303's progress notes revealed a Nurse's Note dated 12/11/24 that noted, Administrator was advised by resident that during care a CNA allegedly abuse her. 'I don't know the date that it happened but it was when (LPN 'L') and (CNA 'H') were working and (CNA 'H') was providing care for me. After he (CNA 'H') changed my brief and cleaned me up he grabbed my vagina and it hurt. I reported it to the nurse (LPN 'L'). DON (Director of Nursing) and administrator interviewed resident and completed a skin/pain assessment on resident A review of a Statement of Witness signed by CNA 'H' on 12/11/24 revealed, On [DATE] 11-7P during my final change, (R303) complained that I was a little rough wiping her .The very next week I had her again and she said that she did not want me as her aide and I swapped her with my hall partner .When this occurred, I reported to the nurse that she said I was too rough with her . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Statement of Witness signed by LPN 'L' on 12/16/24 revealed, I worked November 26, 7pm-7am first floor and I was the nurse for (R303). I recalled answering her light towards the end of the shift (near the morning). She told me at that time 'I don't want him (CNA 'H') taking care of me'. I asked her why and she did not give me a reason outside of her just not wanting him to take care of her . On 2/6/25 at 4:00 PM, an interview was conducted with the facility's Administrator, who was the Abuse Coordinator for the facility. The Administrator (who was not employed by the facility at the time of the above allegation) was queried about the protocol when a resident alleged abuse and reported staff were to notify the Administrator immediately and the Administrator was responsible to report the allegation to the State Agency within two hours. A review of a policy titled, Abuse, Neglect and Exploitation, revised 1/1/22, revealed, in part, the following, . Reporting of all alleged violations to the Administrator, state agency .and to all other required agencies . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .

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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** 32568 This citation pertains to Intake Number(s): MI00149262, MI00148192, and MI00148747 Based on observation, interview, and record review, the facility failed to conduct a thorough investigation into allegations of staff to resident abuse, initiate interventions to prevent further abuse from occurring during the investigation period, and report the results of the investigation to the State Survey Agency (SSA) for three (R303, R310, and R305) of Findings include: R310 A review of a Facility Reported Incident (FRI) submitted to the State Survey Agency (SSA) on 11/6/24 revealed an allegation made by R310 that Certified Nursing Assistant (CNA) 'H' was rough with her and held her arm while providing care on the midnight shift .staff member was immediately suspended pending investigation. It was noted that as of 11/19/24, an investigation was not submitted to the SSA. On 2/4/25 at 10:15 AM, the Administrator was asked to provide the facility's investigation into the above alleged incident concerning R310 and CNA 'H'. The following was revealed: On 2/6/25 at approximately 12:00 PM, R310 was observed lying in bed. An interview was attempted at that time. R310 said she was tired and did not engage in further conversation. A review of R310's clinical record revealed R310 was admitted into the facility on [DATE] with diagnoses that included: Alzheimer's Disease. A review of Minimum Data Set (MDS) assessments dated 10/15/24 and 1/15/25 revealed R310 had severely impaired cognition, no behaviors, required partial/moderate assistance with bed mobility, and was dependent on staff assistance for toileting hygiene. A review of R310's progress notes revealed a Nurses' Note dated 1/6/25 written by the Director of Nursing (DON) that read, Resident states that the midnight CNA was changing her and was rough providing care . abuse coordinator notified . A printed email that indicated the facility's former Administrator (Administrator 'M') submitted the incident report regarding R310 to the SSA on 11/6/24. The email noted, .Based on the information provided, your investigation submission is due no later than 11/14/24 . There was no summary of the facility's investigation findings included in the file provided by the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Statement of Witness completed by CNA 'H' on 11/6/24, documented by Administrator 'M' and signed by CNA 'H', revealed CNA 'H' reported the following: (CNA 'O') endorsed the resident to me and informed .me that she (R310) was refusing care. I continued to check on her throughout the night because she continued to refuse care and I reported it to the nurse. Toward the end of the night, around 6am I went in to change the resident and she became combative with me, she was swatting at my arms and hands, scratching me, and she bent my fingers back. She threatened to shoot me. She scratched my arm. I carefully continued the process to get her brief changed. She was cussing at me, using profanity and the like. Her roommate was asking her to stop yelling from ton the other side of the curtain . A Statement of Witness signed by CNA 'O' on 11/11/24 revealed, .She (R310) is agitated and combative most of the time. She usually refuses all care being provided. That day I did not notice anything out of the norm. I endorsed her to the oncoming CNA and left that unit . A Statement of Witness signed by Licensed Practical Nurse (LPN) 'P' on 11/6/24 revealed LPN 'P' worked the 7:00 PM to 7:00 AM shift on 1/5/25 with CNA 'H'. The statement noted, Resident (R310) was upset with roommate and agitated all night. CNA came to me about the resident and said she was combative and did not want him to change her .The CNA reported numerous times that she was refusing care and that she scratched his arm .When she was given medication, she calmed down and was able to be changed . (It should be noted that it was said in CNA 'H's statement that he continued carefully to change R310's brief despite the resident's agitation and combativeness. A review of an incident report included in the investigation file revealed, Resident stated that when care was being provided on midnight shift that the CNA was being rough. When writer asked what he had done she stated that he held her arm while providing care in the attempt of changing her brief. There was no evidence of any further investigation (other than obtaining statements), such as interviews with other residents or what the outcome of the investigation was, including what was done to prevent further incidents of potential abuse. On 2/6/25 at approximately 3:00 PM, the Administrator was asked to confirm if there was any additional information regarding the investigation into R310's allegation of rough care by CNA 'H'. The Administrator reported she would look into it. It should be noted that the Administrator did not work in the facility at the time of the alleged incident. On 2/6/25 at 4:00 PM, and interview was conducted with the Administrator and the DON. The Administrator did not have an explanation as to why there was not a completed investigation or why it was not submitted to the State Agency. The DON who worked in the facility at the time of the facility reported the allegation was investigated by Administrator 'M' and that was who would have submitted the investigation to the SSA. When queried about the outcome of the investigation, the DON did not offer a response. When queried about whether a CNA should continue to provide care to a combative resident who was resisting care, the DON reported they should get the nurse, maybe get a different CNA to provide care, and reapproach later, but not continue to provide care if a resident refused it. When queried about what was done to ensure nobody else was affected by CNA 'H' and how R310 was protected during the investigation, the DON reported CNA 'H' was suspended pending the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CNA 'H's Time Detail (time punches) record revealed CNA 'H' worked on 11/5/24, 11/7/24, 11/8/24, 11/11/24, 11/14/24, 11/16/24, 11/17/24, 11/19/24, 11/21/24, 11/22/24, 11/26/24, 11/27/24, 11/28/24, 11/28/24, 11/30/24, 12/1/24, 12/3/24, 12/5/24, 12/6/24, 12/7/24, 12/9/24, and 12/10/24. A review of CNA 'H's personnel file revealed a Performance Improvement Form dated 12/17/24 that noted, On 12/11/24, (CNA 'H') was reported by a resident to have handled her roughly. Upon investigation, Admin could not substantiate any mishandling to the resident, however, it was determined that (CNA 'H') did not follow the care plan to have a 2 person for assistance to change the resident. (CNA 'H') did pericare by himself during this event . R303 A review of a FRI submitted to the SSA 12/13/24 revealed an allegation was made by R303 that CNA 'H' was rough with her while providing peri-care. On 2/4/25 at 10:15 AM, the Administrator was asked to provide the facility's investigation into the above alleged incident. A review of the investigation revealed, Administrator 'M' was first notified of R303's allegation against CNA 'H' on 12/11/24 and was reported to the SSA on 12/13/24. There was no summary of the facility's investigation either in the file provided or submitted to the SSA as of 2/4/25. On 2/6/25 at 1:00 PM, R303 was observed lying in bed. R303 did not appear to be able to move in bed independently. When interviewed, R303 reported she required assistance from staff to reposition in bed and staff assisted with brief changes. When queried about what occurred with CNA 'H', R303 reported CNA 'H' was assigned to her, checked on her every two hours to see if she needed a brief change, and during his last rounds, R303 needed a brief change. R303 reported CNA 'H' started to change her brief and grabbed my vagina roughly. R303 denied that it was sexual in nature, but said it was mean. R303 reported the incident to LPN 'L'. R303 explained Administrator 'M' (who was no longer employed at the facility) came to talk with her and CNA 'H' did not provide care for her any longer but still worked at the facility. A review of R303's clinical record revealed R303's was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: rheumatoid arthritis. A review of a MDS assessment dated [DATE] revealed R303's had intact cognition and was dependent on staff assistance for bed mobility, and toilet hygiene. A review of R303's progress notes revealed a Nurse's Note dated 12/11/24 that noted, Administrator was advised by resident that during care a CNA allegedly abuse her. 'I don't know the date that it happened but it was when (LPN 'L') and (CNA 'H') were working and (CNA 'H') was providing care for me. After he (CNA 'H') changed my brief and cleaned me up he grabbed my vagina and it hurt. I reported it to the nurse (LPN 'L'). DON and administrator interviewed resident and completed a skin/pain assessment on resident A review of a Statement of Witness signed by CNA 'H' on 12/11/24 revealed, On [DATE] 11-7P during my final change, (R303) complained that I was a little rough wiping her .The very next week I had her again and she said that she did not want me as her aide and I swapped her with my hall partner .When this occurred, I reported to the nurse that she said I was too rough with her . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Statement of Witness signed by LPN 'L' on 12/16/24 revealed, I worked November 26, 7pm-7am first floor and I was the nurse for (R303). I recalled answering her light towards the end of the shift (near the morning). She told me at that time 'I don't want him (CNA 'H') taking care of me'. I asked her why and she did not give me a reason outside of her just not wanting him to take care of her . There was no evidence that the facility thoroughly investigated the alleged incident to ensure other residents were not affected On 2/6/25 at 4:00 PM, an interview was conducted with the facility's Administrator who did not have an explanation as to why a full investigation was not completed or why it was not submitted to the SSA, as she did not work in the facility at the time of the incident. A review of a facility policy titled, Abuse, Neglect and Exploitation dated 1/1/22 revealed, .Investigation of Alleged Abuse, Neglect and Exploitation .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Written procedures for investigations include .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Providing complete and thorough documentation of the investigation . .Protection of Resident .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation . .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 . 34275 R305 A complaint was filed with the SA that alleged on or about 12/5/24 the facility called the police and falsified statements that R305 attempted to assault their roommate, was sent to the hospital for psychiatric services and was not able to contact the facility from the hospital regarding their return. On 2/6/25 at approximately 10:30 AM, R305 was observed lying in bed. The resident was alert, calm and able to answer all questions asked. R305 was queried about their stay at the facility and any incidents that resulting in the police escorting them to the hospital. R305 noted that there was an incident with a roommate that occurred on 12/5/24. R305 reported that the resident's roommate did not want the door closed and started to call them the N word repeatedly. R305 noted it made them angry and they started yelling back at them. The resident reported that Unit Manager X entered the room with multiple police officers and told the police that they tried to attack their roommate and they were taken out of the facility against their wishes and sent to the hospital. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the R305's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: fracture of lower and upper right femur/leg, fracture of right arm and fracture of right ulna. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). Continued review of R305's clinical record, documented, in part, the following: 12/5/24: Psych Eval: Printed and signed 12/6/24 (12:19 AM): Facility requested psych eval for mood as pt. (patient) made suicidal comment .Provider informed facility that he did not have suicidal ideation and intent. But this morning he attempted to hit his roommate and chased him. Staff said that he will be sent out due to violent behavior . 12/5/24: Transfer Form: .Transfer is .b. Unplanned .other reason for transfer: suicidal ideations, assaultive towards peer . *It should be noted that there were no addition notes that detailed violent behavior towards their roommate or suicidal ideations made on 12/5/24; there were no further notes/documents that indicated the resident was assaultive towards peers and/or description of the incident with their roommate. A request was made for any Incident/Accident (IA) reports. No IAs pertaining to R305 either detailing suicidal ideations and/or violent behavior towards roommate were provided by the end of the Survey. On 2/6/25 at approximately 12:15 PM, an interview was done with UM X. UM X was asked about the incident that occurred on 12/5/24 and why the resident was sent out for a psychiatric evaluation. UM X reported that they did not observe any incident. However, the midnight nurse reported to them an incident involving R305 and their roommate. UM X noted that when they entered the building R305's roommate had been transferred to another room. When asked if they interviewed any residents or staff to determine what occurred, UM 'X noted that they just completed the transfer form. They additionally noted that they believed a few days prior to the incident with their roommate, they expressed suicidal thoughts to another nurse. UM X was asked about the requested psych eval noted above. They indicated that the Social Worker might be aware of what happened and possibly Nurse Z. On 2/6/25 at approximately 1:10 PM, an interview was conducted with Social Service Staff Y. When asked if they were familiar with any behavior issues pertaining to R305 they noted that they were not a licensed social worker and believed they were off the day the resident was sent to the hospital. They also reported that their supervising Social Worker was not employed at the time of the incident. On 2/6/25 at approximately 1:40 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked if they were aware of any investigations completed regarding R305 for either their aggressive behavior towards their roommate and/or alleged suicidal thoughts. The DON reported that they were not really involved in the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at approximately 3:30 PM, an interview was conducted with the Administrator/Abuse coordinator. The Administrator was new to the facility and not employed at the time of the incident. However, when asked the facility's protocol pertaining to resident-to-resident incidents, the Administrator reported that generally an investigation is done to determine what occurred and what follow-up interventions needed to be implemented and if and when the issue should be reported to the State Agency. On 2/6/25 at approximately 3:37 PM, a phone interview was conducted with Nurse Z. When asked about the incident involving R305 and their roommate, Nurse Z reported that they were fighting about the door being open or closed. They noted they reported the incident to UM X. When asked if they were interviewed by staff as to what occurred, they replied No.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00149262 and MI00148747. Based on observation, interview, and record review, the facility failed to develop and implement care plans for activities of daily living and suicidal ideations/behaviors for two (R303 and R305) of 14 residents reviewed for care plans. Findings include: R303 A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) 12/13/24 revealed an allegation was made by R303 that Certified Nurse Assistant (CNA) 'H' was rough with her while providing peri-care. On 2/6/25 at 1:00 PM, R303 was observed lying in bed. R303 did not appear to be able to move in bed independently. When interviewed, R303 reported she required assistance from staff to reposition in bed and staff assisted with brief changes. When queried about what occurred with CNA 'H', R303 reported CNA 'H' was assigned to her, checked on her every two hours to see if she needed a brief change, and during his last rounds, R303 needed a brief change. R303 reported CNA 'H' started to change her brief and grabbed my vagina roughly. R303 explained that CNA 'H' was the only staff member providing care to her at the time of the alleged incident. A review of R303's clinical record revealed R303's was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: rheumatoid arthritis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R303 had intact cognition and was dependent on staff assistance for bed mobility and toilet hygiene. A review of R303's care plans revealed a care plan initiated on 10/26/23 that noted, Resident has an ADL (activities of daily living) performance deficit related to Rheumatoid arthritis, contractures and prefers to stay in bed . It was noted in the care plan that an intervention for two person assist for toileting was initiated on 10/26/23. A review of R303's progress notes revealed a Nurse's Note dated 12/11/24 that noted, .After he (CNA 'H') changed my brief and cleaned me up he grabbed my vagina and it hurt . On 2/4/25, the Administrator was asked to provide the facility's investigation into the above alleged incident. The investigation revealed the following: A review of a Statement of Witness signed by CNA 'H' on 12/11/24 revealed, On [DATE] 11-7P during my final change, (R303) complained that I was a little rough wiping her .The very next week I had her again and she said that she did not want me as her aide and I swapped her with my hall partner .When this occurred, I reported to the nurse that she said I was too rough with her . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CNA 'H's personnel file revealed a Performance Improvement Form dated 12/17/24 that noted, On 12/11/24, (CNA 'H') was reported by a resident to have handled her roughly. Upon investigation, Admin could not substantiate any mishandling to the resident, however, it was determined that (CNA 'H') did not follow the care plan to have a 2 person for assistance to change the resident. (CNA 'H') did pericare by himself during this event . On 2/6/25 at 4:00 PM, an interview was conducted with the Director of Nursing (DON) who confirmed CNA 'H' should have had a second staff person to assist while changing R303's brief according to her plan of care. 34275 A complaint was filed with the State Agency (SA) that alleged on or about 12/5/24, R305 and their roommate got into an argument that escalated to the point where the resident was sent to the hospital based on suicidal ideations and/or violent behavior(s). On 2/6/25 at approximately 10:30 AM, R305 was observed lying in bed. The resident was alert and able to answer all questions asked. R305 was queried about their stay at the facility and any incidents that resulting in them being discharged to the hospital. R305 reported that they had been a resident at the facility for approximately two years following a significant auto accident. They noted that there was an incident with a roommate that occurred on 12/5/24. R305 reported that the resident's roommate did not want the door closed and started to fight with the resident and started yelling at them calling them the N word. Following the incident, the police arrived and took them to (name redacted) hospital for a psychiatric evaluation based on suicidal ideation/threats and the issue with their roommate. A review of the R305's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: fracture of lower and upper right femur/leg, fracture of right arm and fracture of right ulna. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition). 12/1/24: Nurses Notes: Writer asks resident was he okay? Resident states if he had a gun with one bullet he would be better . do you have a plan to hurt oneself? Resident states only if he had access to a gun. But that he was really irritated due to breaking up with girlfriend. Writer confronts resident and says that someone is always around to talk if need be . 12/5/24: Psych Eval: Printed and signed 12/6/24 (12:19 AM): Facility requested psych eval for mood as pt. (patient) made suicidal comment .Provider informed facility that he did not have suicidal ideation and intent. But this morning he attempted to hit his roommate and chased him. Staff said that he will be sent out due to violent behavior . 12/5/24: Transfer Form: .Transfer is .b. Unplanned .other reason for transfer: suicidal ideations, assaultive towards peer . R305's Care Plan was reviewed regarding interventions pertinent to suicidal ideations. No documentation was noted in R305's care plan following their comment to nursing staff on 12/1/24 or their return from the Hospital on 12/12/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at approximately 12:15 PM, an interview was done with UM X. UM X was asked about the incident that occurred on 12/5/24 and why the resident was sent out for a psychiatric evaluation. UM X reported that they did not observe any incident. However, the midnight nurse reported to them an incident involving R305 and their roommate. When asked if their care plan had been updated , UM X noted they were not aware and suggested talking to the Social Worker. On 2/6/25 at approximately 1:10 PM, an interview was conducted with Social Service Staff Y When asked if they were familiar with any behavior issues pertaining to R305 and possible updates in their care plan they noted that they were not a licensed social worker and believed they were off the day the resident was sent to the hospital. They also reported that their supervising Social Worker was not employed at the time of the incident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00149629 and MI00149369. Based on observation, interview, and record review, the facility failed to follow nursing professional standards of practice related to wound treatment and entering medication orders for two (R301 and R302) of two residents reviewed. Findings include: On 2/4/25 at 11:00 AM, R301 was observed in bed. A dressing applied to R301's right foot was observed to be soiled in the area of his toes. The dressing was dated 2/3/25 with initials (discovered to be Licensed Practical Nurse - LPN 'Q') written with thick black marker which was written over thinner writing that was labeled 1/31/25. On 2/4/25 at 11:09 AM, an observation of the dressing on R301's right foot was conducted with Unit Manager, Registered Nurse (RN) 'U'. When queried about the date of 2/3/25 written on top of the date of 1/31/25, RN 'U' did not offer a response. On 2/4/25 at 11:19 AM, an observation of the dressing on R301's right foot was conducted with the DON who replied They just changed it! When queried about who and when, the DON pointed to the dressing which was dated for the day prior, 2/3/25. The DON reported she looked at the dressing and saw the date from yesterday but did not notice the date underneath. The DON reported the treatment should be done according to the physician's order and signed out on the Treatment Administration Record (TAR) when completed. On 2/5/25 at 10:06 AM, an interview was conducted with LPN 'Q' via the telephone. When queried about the date of 2/3/25 written on R301's dressing to his right foot with writing underneath labeled 1/31/25, LPN 'Q' confirmed that he wrote the date on the dressing without actually performing wound care. LPN 'Q' reported he did it because he was assigned to too many residents and could not complete all of his nursing tasks. A review of R301's Physician's Orders and Treatment Administration Record for February 2025 revealed an order to Cleanse right great toe and second toe with wound cleanser and pat dry. Apply calcium alginate AG with honey-based gel and wrap with dry dressing every day shift . It was signed off on the TAR that the treatment was administered on 2/1/25 and 2/2/25, despite the dressing indicating the last treatment was done on 1/31/25. On 2/2/25, there was no nurse's signature to indicate a treatment was administered to R301's right toes. A review of R301's clinical record revealed R301 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute respiratory failure with hypoxia. A review of a Minimum Data Set (MDS) dated [DATE] revealed R301 had moderately impaired cognition and had open lesions to his skin. 34275 R302 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A complaint was filed with the State Agency (SA) that alleged that the facility stopped providing IV (intravenous) antibiotics as ordered for R302. A review of the R302's clinical record detailed the following: 12/13/24: Patient Discharge Summary : admitted (to hospital) 12/4/24 .Projected discharge date to facility 12/13/24 .Primary Diagnosis: Bed Sores .Assessment and Plan .Left trochanteric wound .debridement done by surgery .Recommend: .IV antibiotics .Prescription Details: Rx (medication): Zosyn (Piperacillin Sod-Tazobactam) 4.5 g (grams) IV Piggyback q8h (every 8 hours) for 28 days . Following their stay at the hospital, R302 was admitted to the facility on [DATE] with diagnoses that included: acute osteomyelitis (inflammation of the bone caused by infection), fecal impaction and quadriplegic cerebral palsy. An initial assessment (12/13/24) completed by Nurse N noted the resident had two infected wounds and was to receive antibiotic treatment (ABT) at the facility. The initial assessment and following Minimum Data Set (MDS) noted the resident was severely cognitively impaired and required extensive help with all activities of daily living. Order details (12/13/24):Order summary: Piperacillin Sod-Tazobactam .use 4.5 gram intravenously every 8 hours for infection for 7 days . *End date of 12/20/24. PMR (physician medicine and rehabilitation) progress note (12/17/24): .Patient admitted to facility on 12/13/24 .PMR consulted to evaluate rehab needs .I personally reviewed the hospital records .continues with RUE right upper extremity) PICC (peripherally inserted central catheter) for antibiotic tx (treatment) of Osteomyelitis (infection in bone) till 1/8/25 . *If order was correct R302 would have received 28 days of antibiotic. R302's MAR (medication administration record) noted the resident received the above order (Piperacillin) starting on or about 12/13/24. The antibiotic was noted to be provided through 12/20/24 (last dose at 2 PM). The MAR did not document that the medication was provided on 12/18/24 at 2PM or 12/19/24 (2 PM). Further review noted that there were no more attempts to administer the medication 12/21/24 through 12/30/24. The MAR noted attempts to administer the antibiotic on 12/31/24 at 2 PM and 10 PM with a note that indicated the medication was hold/see progress note. 12/31/24: Note: Piperacillin Sod-Tazobactam So Intravenous Solution .use 4.5 gram intravenously every 8 hours for Osteomyelitis for 21 days begin after picc line is placed awaiting IV to be placed in. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at approximately 4:00 PM, an interview was conducted with Nurse N who was queried as to the facility protocol for newly admitted patients, specifically ensuring necessary medications prescribed by hospital physicians are provided to the resident(s) during their stays. Nurse N reported that upon admission nursing staff will review the hospital discharge records, including, but not limited to medication orders. Once they review the orders they are sent to the residents treating physicians and nursing staff will place the orders in to the residents clinical records. Nurse N was asked about R302 as it appeared they had completed the initial assessment. Nurse N noted that they had been working with another Nurse (herein Nurse E) who put in R302's medication orders. Nurse N was asked if they were aware that the initial order expected the facility to provide IV antibiotics for 28 days and it appeared as the original order was only for 7 days. Nurse N noted that they were aware that there had been some confusion, and the facility tried to restart the medication again but there were some issues with the PICC line. On 2/5/25 at approximately 3:28 PM, an interview was conducted with Nurse 'E. Nurse E reported that they had been employed by the facility for about six months. When asked if they were familiar with R302, they noted that they were. When asked about entering R302's IV order antibiotic order upon their admission, Nurse E reported that they recently reprimanded by the Director of Nursing (DON). Nurse E could not provide a specific date that the DON spoke with them, but noted they were educated on double checking orders and ensuring correct orders are put in place. On 2/5/25 at approximately 1:40 PM, an interview was conducted with the DON. The DON was queried as to the failure to correctly place R302's hospital order for antibiotics. The DON replied that they were aware of the situation and had educated Nurse E.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Deficient Practice Statement #1 This citation pertains to Intake # MI00149906. Based on interview and record review, the facility failed to timely assess and intervene for a resident who had a new tracheostomy (an artificial opening in the windpipe to assist with breathing), and who alerted staff that they were in distress by using non-verbal gestures, resulting in the death for one (R313) of three residents reviewed for a change in condition. Findings include: The IJ began on [DATE] when R313 had encountered a change in condition and notified CNA B. The Administrator was notified of the IJ on [DATE] at 2:05 PM. A plan of removal was requested at that time to remove the immediacy. The IJ was removed and verified on [DATE] based on the facility's implementation of an acceptable plan of removal. Although the immediacy was removed, the deficient practice was not corrected and remained isolated with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency (SA). On [DATE] at 10:07 AM, Family Member (FM) R was interviewed via telephone. FM R was asked about the death of R313. FM R reported that before the incident, the facility could not get R313's food texture right. FM R further reported that often themselves or a sibling would be present at the facility at mealtimes because they did not trust the facility to provide the correct diet texture. R313 was on tube feeding in addition to getting food by mouth. FM R stated on the day R313 expired in the facility, a staff member called their sibling and stated R313 aspirated (choked). FM R stated their sibling received a call from a female nurse who was crying and stated that R313 had passed away because they aspirated. FM R stated when they arrived at the facility with their sibling the food tray for R313 was still in the room, and the food was observed to be the incorrect texture. FM R reported family members were usually present at the facility for R313's meals due to previous incidents of the kitchen staff providing the incorrect texture. FM R stated the one dinner they were not present for is the day R313 died . FM R went on to say they provided R313 a board and paper to communicate due to difficulties communicating with a tracheostomy. FM R reported that R313 utilized the board often to communicate their needs. FM R reported, when they went to the facility on the evening of R313's death their communication board was observed to have RT (Respiratory Therapist) written on there by R313. FM R reported, the paper observed in R313's room also had noted that RT was needed. FM R reported, R313 had a fear of choking, so for R313 to die from choking was heart breaking. FM R reported the facility RT manager said that R313 should have been on aspiration precautions and signage was supposed to be placed over R313's bed to ensure all staff knew what to monitor R313 for when eating, drinking and ensuring the bed was in the correct position. FM R reported, R313 was supposed to have assistance with meals and family came daily to assist. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review revealed that R313 was admitted to the facility on [DATE] with the diagnosis of Hemiplegia and hemiparesis following a cerebral infraction affecting the left side, acute and chronic respiratory failure with hypoxia, dysphagia-oropharyngeal phase (difficulty with swallowing), Gastrostomy status(a tube surgically inserted in the abdomen for eating) and tracheostomy status. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status Score (BIMs) of 9, which indicated moderate cognitive impairment. A further review of the record revealed a nursing progress note dated [DATE] at 9:18AM that documented, Writer entered into residents' room at 19:45 (7:45 PM) on [DATE]. Upon entering room writer noticed resident skin was discolored, immediately checked carotid pulse absent. Called residents name-no response. Code blue called and immediately began compressions. Staff in room with defibrillator. 911 called. CPR (cardiopulmonary resuscitation) continued. 20:09 (8:09PM) resident pronounced dead by EMS (emergency medical services)/MD (medical doctor). On [DATE] at 2:00 PM, Nurse A was interviewed via telephone. Nurse A was asked about the day of R313's death. Nurse A reported, they were short on nurses for the afternoon shift, and they were the only nurse on the unit until about 7:00 PM. Certified Nursing Assistant (CNA) B was assigned to R313. Nurse A reported around 5:30 or 6:00 PM, CNA B who was at the end of the hallway stated Uhh they want you. Nurse A reported that they asked CNA B who wanted them, and CNA B just walked away and went on break. Nurse A reported, they had worked with CNA B before and they were always zoned out, did not communicate well and took nothing serious. Nurse A reported that they continued to prepare medications and start medication pass. Nurse A reported, they completed the first cart of medications, around 6:30 or 7:00 PM when CNA B asked them, Did you ever see what they wanted? Nurse B reported, they asked CNA B which resident and what room. CNA B indicated R313's room. Nurse A reported that CNA B did not specify the nature of the situation. Nurse A reported after they prepped medications for the back cart, they entered R313's room. Nurse A noticed R313's head of bed was not elevated, which was abnormal for that resident who preferred their bed at a 90-degree angle. When Nurse A went to adjust the bed for R313 they noticed R313 face was a different color. Nurse A explained they checked R313's pulse and quickly started CPR and 911 was called. Nurse A reported EMS (emergency medical services) told them R313 aspirated on fruit punch. Nurse A reported they informed the family of R313's death. Nurse A reported they followed up with CNA B after R313's death, and asked CNA B was R313 the resident who needed help earlier. CNA B stated, They (R313) were choking and grabbing my arm [NAME]. It was weird they (R313) wouldn't let me go. On [DATE] at 3:00 PM, CNA B was interviewed. CNA B was asked what they remembered about R313's death. CNA B reported, when they came on shift R313 was squirming around on the bed sideways. CNA B reported that R313 was acting up and they were trying to get R313 to calm down. CNA B reported R313 was tripping. CNA B reported, that R313 wrote on their communication board and papers RT (referencing the respiratory therapist). CNA B further reported they went to notify two RTs (RT AA and RT BB) for their help with R313. RT AA and RT BB told CNA B they don't go on that side (to the unit where R313 resided), and the nurse can suction a resident. CNA B was asked if they reported the concern with R313 to Nurse A. CNA B responded, No one was listening man. CNA B was then asked why they went on break, leaving R313 alone and in distress. CNA B did not respond. On [DATE] at 8:42 AM and 4:04PM, RT AA , was called with no response. On [DATE] at 8:56 AM and 4:34 PM, RT BB was called with no response. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 1:00 PM, a request was made to review the two east camera footage for [DATE]. Regional Corporate Personnel CC reported that the cameras only went back for ten days and the footage was not available. On [DATE] at 3:23 PM, the facility was asked to provide the investigation documents pertaining to R313's death. A review of CNA B's personnel file revealed a document titled Performance Improvement Form dated [DATE] that read, . On [DATE] (CNA B) was the assigned CNA for resident (R313 room number) the resident aspirated resulting in her expiring. (CNA B) alerted the assigned nurse of a resident possibly needing assistance. However, he did not state which resident or what the need was at that time. (CNA B) later reported to the assigned nurse that the resident was choking as she was grabbing his arm also stating that it was weird. (CNA B) left the resident and went on break without ensuring that she was properly cared for and safe . It is expected that if a resident is choking that the CNA will provide the Heimlich maneuver technique used for a conscious choking victim . is also expected to stay with a resident and call out for help maintain the resident's safety to the best of his ability until help arrives . The form indicated that CNA B was suspended. On [DATE] at 4:09 PM, The Director of Nursing (DON) was interviewed about the death of R313. The DON reported, they were in the facility when a code blue was called for R313. The DON was asked what was expected from CNA B when they observed R313 in distress. The DON reported that CNA B should have reported clearly to Nurse A and the RTs on who and what the concern was. The DON reported, Nurse A and the RTs should have obtained more information from CNA B and assessed the resident timely. On [DATE] at 4:15 PM, RT Manager C was interviewed. RT Manager C was asked what the RT responsibilities were when notified of the change in condition for R313. RT Manager C reported the RTs should have assessed and treated the Resident timely. A further review of the record showed that R313 had no care plan in for aspiration precautions, that they were a one person assist with mealtimes. The care plan also showed that R313 had interventions to observe for physical/non-verbal indicators of discomfort or distress and follow up as needed. A review of the case report from local police department dated [DATE] at 8:01 PM, revealed, . Subject Sudden Death . information . (R313) alive at approximately 1800hrs (6:00PM). (Nurse A) found (R313) unresponsive at approximately 1958hrs (7:58 PM) and started CPR (Local Fire department) medical personnel also stated that (R313) was full of fluid and (facility name) staff stated, (R313) might have had aspirated from red fruit punch (shown in photos taken). The Immediate Jeopardy that began on [DATE] was removed and the deficient practice corrected on [DATE] when the facility took the following action to remove the immediacy: Identification of Residents Affected or Likely to be affected: The facility took the following actions to address the citation and prevent any residents from an adverse outcome. (Completion Date: [DATE]). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Current residents residing in the facility were assessed by licensed nurses to ensure that residents with changes in condition needs were met and that physicians, RP/guardians were notified on [DATE]. Actions to Prevent Occurrence/Recurrence: Education: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: [DATE]). On this date [DATE] we educated nurses, CNAs, and RT on the following: Head to toe observation for changes in condition for CNAs posted at nurses' station and handout given. Head to toe observation, clinical pathways for changes in condition and respiratory for Nurses posted at medication carts and handout given. Hierarchy Notification Steps handout given to nurses, CNAs, and RT. Notification of Hierarchy (Steps of Notification of Changes) Notify floor nurse assigned to resident of changes in condition. If nurse does not respond notify the RT. If the RT doesn't respond notify the on call manager. If the on call manager doesn't respond notify the DON. Verbal and non-verbal signs of distress Signs of distress, both verbal and nonverbal, can include: changes in voice tone (e.g., shaky, high-pitched), crying, sighing, complaining, withdrawn behavior, avoiding eye contact, clenched fists, pacing, fidgeting, facial expressions like frowning or grimacing, rapid breathing, sweating, changes in appetite, and disrupted sleep patterns. Verbal signs of distress: Changes in voice tone: Speaking in a higher pitch, trembling voice, or a quieter than usual tone. Complaints: Expressing physical discomfort, pain, or emotional distress through verbal complaints. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Negative self-talk: Putting oneself down or making pessimistic statements. Crying or sobbing: Tears as a visible expression of emotional distress. Swearing or using strong language: May indicate heightened frustration or anger. Asking for help: Directly stating a need for support. Nonverbal signs of distress: Facial expressions: Frowning, furrowed brows, narrowed eyes, pursed lips, grimacing Body language: Crossed arms, hunched posture, avoiding eye contact, tense muscles, fidgeting Physical changes: Sweating, rapid breathing, increased heart rate, flushed face Changes in movement: Pacing, rocking, restless behavior, sudden withdrawal Vocalizations: Sighing, moaning, groaning, muttering Changes in appetite: Loss of interest in food or overeating Sleep disturbances: Difficulty falling asleep, frequent waking, insomnia Self-harm behaviors: Picking at skin, pulling hair, substance abuse Important considerations: Context matters: What might be considered a sign of distress in one situation may be normal behavior in another. Individual differences: People express distress differently, so it's important to be sensitive to individual cues. Observe patterns: Look for recurring behaviors or changes in behavior to better assess distress. There was no additional information provided at the exit of survey. 32568 Deficient Practice #2 This citation pertains to Intake Number(s): MI00149629. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview, and record review, the facility failed to prevent, identify and accurately assess new skin breakdown and administer treatment to vascular wounds according to physician's orders for two (R300 and R301) of three residents reviewed for skin integrity, resulting in R300 developing an open lesion to the back of the knee with exposed tendon and the potential worsening wounds to R301's toes. Findings include: R300 A review of a complaint submitted to the State Survey Agency (SSA) revealed an allegation that R300 had wounds and was not being positioned frequently. It was also alleged that the facility was short of staff with only one nurse handling wound care. On [DATE] at 10:26 AM, R300 was observed lying in bed in a fetal position with his legs bent and tucked up toward his abdomen. R300 was positioned to the right side. No pillows were observed to offload pressure from R300. A sign hung by R300's family member noted a specific patterned pillow was to be used to position R300. The patterned pillow was observed at the foot of the bed. R300 was receiving nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube surgically inserted into the stomach to deliver nutrition. R300 had a tracheostomy (a tube surgically inserted into the windpipe to assist with breathing). When spoken to R300 did not respond or make eye contact. On [DATE] at approximately 12:30 PM, R300 was observed in bed. A family member was visiting. When queried about any concerns, the family member explained R300 had a wound between his right shin and the knee on the back side of his leg. According to R300's family member, she discovered the wound when she noticed blood on R300's bedding a few months ago and when they looked behind R300's knee there was an open area with exposed tendon which has not yet healed. On [DATE] at 8:20 AM, 10:00 AM, and 11:32 AM, R300 was observed lying in bed in the same position. There were no pillows or devices being used to extend R300's right leg. On [DATE] at approximately 4:00 PM, an interview was conducted with the facility's wound care coordinator, Licensed Practical Nurse (LPN) 'D'. When queried about the skin impairment to the back of R300's right knee, LPN 'D' reported R300 had an open lesion to the back of the right knee caused by moisture. LPN 'D' reported that when she first assessed the skin impairment the tendon was exposed. LPN 'D' reported the open lesion has not healed. When queried about any preventative measures that were in place to prevent breakdown to that area and to prevent worsening and promote healing, LPN 'D' reported she would look into it. A review of R300's clinical record revealed R300 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute respiratory failure with hypoxia, contractures, metabolic encephalopathy, nontraumatic chronic subdural hemorrhage, and hydrocephalus. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R300 had no speech, highly impaired hearing, severely impaired cognition, had upper and lower bilateral range of motion impairment, was dependent on staff for bed mobility, transfers, and all activities of daily living (ADLs), and had two unhealed pressure ulcers, an open lesion, and moisture associated skin damage (MASD). A review of a Skin Assessment completed on [DATE] revealed R300 did not have any new or existing abnormal skin areas. It should be noted that at that time R300 did have two existing pressure ulcers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a Wound Assessment completed by LPN 'D' and a Surgical Note completed by the consultant wound provider on [DATE] revealed R300 had a new, in-house acquired open lesion to the right popliteal fossa (the diamond shaped space located in the back of the knee joint) that measured 0.6 cm (centimeters) in length x (by) 1.8 cm in width x 0.5 cm in depth. It was documented that tendon exposed. A review of a Skin and Wound Evaluation dated [DATE] revealed R300 had an open lesion to the right popliteal fossa that measured 0.7 cm x 1.1 cm x 1.0 cm. It was documented the wound was healable. In the notes section it was documented that wound has increased in size. Wound not likely to heal d/t (due to contractures) .offload at tolerated . A review of the Wound Evaluation which included a photo of the wound revealed R300's tendon was exposed. A review of the previous wound consult notes documented by the wound provider on [DATE] revealed the wound decreased in size and was improving. A review of R300's Physician's orders revealed orders beginning on [DATE] that recommended offloading wound with positioning leg in as much extension as possible. On [DATE] at 1:35 PM, an interview with the Director of Nursing (DON) was conducted. When queried about what interventions were put into place to prevent skin breakdown for residents with contractures, the DON reported they would have restorative care and we can't predict something that would pop up. At that time, R300's skin assessment on [DATE] and wound assessment on [DATE] were reviewed with the DON. The DON reported the weekly skin assessments should be accurate to what is going on with the resident. When queried about what was in place to prevent skin breakdown behind R300's knee prior to the development of a open lesion with exposed tendon and what additional precautions were added after the skin impairment was identified, the DON reported she would look into it. On [DATE] at approximately 2:00 PM, LPN 'D' followed up regarding the information requested from the DON. When queried about any preventative measures that were implemented prior to R300's skin breakdown on the back of the right knee and what additional measures were put into place after the development of the open area, LPN 'D reported she would look into it. On [DATE] at 2:22 PM, LPN 'D' followed up and reported she found old orders for passive ROM, but nothing in place to keep that area free of moisture or to help extend the leg before or after the development of the open lesion. R301 On [DATE] at 10:30 AM, R301 was observed in bed sleeping. R301's right foot was wrapped with dressing which was soiled in the area of his toes which were sticking out of the end of the blanket. On [DATE] at 11:00 AM, R301 was observed in bed. The blanket was no longer covering R301's right foot. The dressing applied to R301's right foot was soiled in the area of his toes. The dressing was dated [DATE] with initials (discovered to be Licensed Practical Nurse - LPN 'Q') written with thick black marker which was written over thinner writing that was labeled [DATE]. On [DATE] at 11:09 AM, an observation of the dressing on R301's right foot was conducted with Unit Manager, Registered Nurse (RN) 'U'. When queried about the date of [DATE] written on top of the date of [DATE], RN 'U' did not offer a response. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:19 AM, an observation of the dressing on R301's right foot was conducted with the DON who replied They just changed it! When queried about who and when, the DON pointed to the dressing which was dated for the day prior, [DATE]. The DON reported she looked at the dressing and saw the date from yesterday but did not notice the date underneath. On [DATE] at approximately 11:25 AM, R301's right foot and toes were observed with RN 'U'. RN 'U' unwrapped the dressing from R301's foot. The dressing was soiled and stuck to R301's toes which required RN 'U' to moisten the dressing in order to remove it. The top of R301's right great toe was observed to have an open area described by RN 'U' as Red and beefy, draining, with white patches on the inside of the toe. The top of R301's second toe was observed with an open area described by RN 'U' as a little red and a little white, but not draining as much as the other toe. There is white on the side of the toe. R301's right great and second toe were dark in color in comparison to his other toes and the rest of the right foot. On [DATE] at 10:06 AM, an interview was conducted with LPN 'Q' via the telephone. When queried about the date of [DATE] written on R301's dressing to his right foot with writing underneath labeled [DATE], LPN 'Q' confirmed that he wrote the date on the dressing without actually performing wound care. LPN 'Q' reported he did it because he was assigned to too many residents and could not complete all of his nursing tasks. A review of R301's Physician's Orders and Treatment Administration Record for February 2025 revealed an order to Cleanse right great toe and second toe with wound cleanser and pat dry. Apply calcium alginate AG with honey-based gel and wrap with dry dressing every day shift . It was signed off on the TAR that the treatment was administered on [DATE] and [DATE], despite the dressing indicating the last treatment was done on [DATE]. On [DATE], there was no nurse's signature to indicate a treatment was administered to R301's right toes. A review of R301's clinical record revealed R301 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute respiratory failure with hypoxia. A review of a Progress Note from a podiatry consult dated [DATE] revealed R301 was diagnosed with peripheral vascular disease and had multiple wounds to the right foot. It was recommended that an arterial Doppler be completed. A review of a Radiology Results Report dated [DATE] revealed R301 had a right lower extremity arterial Doppler ultrasound completed which revealed monophasic waveforms (slow, blunted systolic blood flow) in the anterior tibial artery (a major blood vessel that supplies blood to the lower leg and foot) with increased velocity, likely related to peripheral vascular disease and monophasic waveforms in the proximal, mid superficial femoral and popliteal arteries (an artery that runs deep in the mid-thigh and through to the knee) in favor of peripheral vascular disease. A review of a Skin and Wound Evaluation dated [DATE] revealed R301 had an Open lesion to the right dorsum first digit (top of great toe) that was in-house acquired that measured 1.4 cm x 2.0 cm x 0.2 cm with evidence of infection (warmth). It was documented that the wound increased in size and R301 was receiving ABX (antibiotics) r/t (related to) soft tissue cellulitis to the right foot. A review of a second Skin and Wound Evaluation dated [DATE] revealed R301 had an open lesion to the top of the right second digit (toe) that measured 1.2 cm x 1.0 cm x 0.2 cm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:15 PM, an interview was conducted with LPN 'D' who said the nurses were required to do weekly head to toe skin assessments and to alert LPN 'D' of any changes (new or worsening) to skin and the floor nurses were required to complete the daily wound treatments. LPN 'D' reported she rounded with the wound provider one time per week. LPN 'D' reported she had been following the progression of R301's toes since she started in her position and indicated although they did not worsen after treatment was not done for three days, he currently was being treated for an infection and it was important to complete the wound care as ordered. A review of a facility policy titled, Wound Treatment Management, revised on [DATE], revealed, in part, the following, .Wound treatments will be provided in accordance with physicians orders . A review of a facility policy titled, Pressure Injury Prevention and Management, revised [DATE], revealed, in part, the following, .Licensed nurses will conduct a full body skin assessment .weekly .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake #MI00148240 Based on observation, interview and record review the facility failed to prevent, timely identify a pressure wound and ensure interventions were in place for one (R309) of three residents reviewed for pressure ulcers resulting in R309 sustaining a facility acquired stage III pressure ulcer to their right ear. Findings include: A complaint was filed with the State Agency (SA) that alleged on 10/16/24 they observed that a piece of skin was missing from R309's ear and blood was observed on the resident's pillow. The complainant further alleged that R309's ear appeared as if it turned black and thought it was because the resident was continuously lying on their right side and not turned frequently. On 2/4/25 at approximately 11:05 AM, R309 was observed lying in bed, a tracheostomy (artifical airway inserted in the windpipe) was present and their head was turned to the right side. Their right ear was not visible. The resident was alert, however not able to communicate. Follow-up observations were conducted on 2/4/25 at approximately 1:00 PM and again at 1:36 PM, the resident was still in the same position as observed at 11:05 AM. At 3:00 PM, R309 was observed in the same position leaning on their right side. A review of the resident's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: chronic respiratory failure, cerebral infarction (stroke) and Lupus (an immune chronic illness). A review of the resident's Minimum Data Set (MDS) noted the resident was severely cognitively impaired and required extensive one to two person assist for most Activities of Daily Living (ADLs). A Turn and Reposition Task (dated 2/4/25) noted inconsistencies in turning. The following times were marked: 3:21 AM (times two), 3:22 AM (times one), 6:13 AM (times one), 9:04 AM(times two), 12:32 PM (times one), 1:47 (times one), 4:33 PM (times one), 8:20 PM (times two) and 10:54 PM (times one). A skin assessment form dated 10/17/24 documented, in part, the following: .Are there any new abnormal skin areas (NO) .Are there any existing abnormal skin areas (YES) .List sites: abdomen, sacrum . *This skin assessment had no documentation pertaining to the resident's ear, nor were there any progress notes indicating issues to the right ear, including blood coming from the resident's right ear. A skin assessment form dated 10/24/24 documented, in part, the following: .Are there any new abnormal skin areas (NO) .Are there any existing abnormal skin areas (YES) .List sites: abdomen, sacrum . *This skin assessment had no documentation pertaining to the resident's right ear. No additional nursing notes were noted in the record. A Wound Evaluation (dated 10/24/24 and including pictures) noted, .Pressure: Stage 3 .Body location: Front Right [NAME] (Outer ear) .acquired: In-house Acquired .Area .89 cm, length 1.44 com, width .76 cm . Deepest point .2 cm .Type: Pressure .Stage 3 .acquired: In-House acquired .Location: Front Right Ear. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan: Focus (date initialed: Resident has impaired skin integrity as evidenced by admission Pressure injury to the right ear (reopening) .(date initiated 10/4/23 .Revision on 10/24/24) .Interventions: .Right ear: Skin prep .Right Ear Calcium Alginate bordered foam .Assist resident with turning and repositioning as needed using positional devices . (10/24/24). Order (10/25/24): Cleanse right ear with wound cleanser. Pat dry. Apply Calcium Alginate to fit open area and cover with a 2x2 bordered foam dressing every day shift for Wound healing . On 2/5/25 at approximately 2:15 PM, an interview was conducted with Wound Nurse D. Nurse D was asked about the facility's protocol for preventing and identifying skin issues. Nurse D reported that residents receive head-to-toe skin assessments by nursing staff weekly. If they become aware of an issue they should report their concerns. Additionally, Nurse D can review assessments and sometimes Certified Nursing Assistance (CNAs) will report concerns. Nurse 'D was queried as to when they became aware of the resident's open area on their right ear as the head-to-toe skin assessments (10/17/24 and 10/24/24) contained no information regarding the resident's ear. Nurse D reported that most likely R309's family brought it to their attention and they initiated the assessment and treatment orders. Nurse D noted that staff should be the ones to report and added they believed nursing staff are often overwhelmed and have too much work. On 2/6/25 at approximately 2:13 PM, an interview was conducted with the Director of Nursing (DON) regarding R309's pressure ulcer on the right ear. The DON reported that the wound was acquired at the facility about two years ago, was resolved and most likely developed again. When asked as to what interventions were in place to prevent the pressure ulcer to the ear and why nursing staff failed to notice a change in their skin, the DON reported that the resident should be turned at least every two hours and documented as done, and that wound care should be notified immediately with a change in condition. A facility policy titled, Pressure Injury Prevention and Management (3/20/24) was reviewed and documented, in part: Policy: The facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries .Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition .define and implement interventions that are consistent with the residents needs .monitor and evaluate the impact of the interventions; or revise the interventions as appropriate .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake # MI00149369 Based on interview and record review, the facility failed to ensure that residents medication orders were entered correctly upon admission for one (R302) of two sampled residents reviewed for antibiotics, resulting in R302 initially missing 10 days of their antibiotic, being sent to the hospital to correct an issue with their PICC (peripherally inserted central catheter) line and needed an extended stay at the facility to ensure they received all antibiotics prescribed. Findings include: A complaint was filed with the State Agency (SA) that alleged that the facility stopped providing IV (intravenous) antibiotics as ordered for R302. Additional allegations noted the failure to follow hospital ordered antibiotics resulted in R302 returning to the hospital on or about 1/1/25 for PICC line placement and then returning to the facility for an extended stay to complete their antibiotics. A review of the R302's clinical record detailed, in part, the following: 12/13/24: Patient Discharge Summary : admitted (to hospital) 12/4/24 .Projected discharge date to facility 12/13/24 .Primary Diagnosis: Bed Sores .Assessment and Plan .Left trochanteric wound .debridement done by surgery .Recommend: PICC .IV antibiotics .Prescription Details: Rx (prescribed medication): Zosyn (Piperacillin Sod-Tazobactam) 4.5 g (grams) IV Piggyback q8h (every eight hours) for 28 days . Following their stay at the hospital, R302 was admitted to the facility on [DATE] with diagnoses that included: acute osteomyelitis (inflammation of the bone caused by infection), fecal impaction and quadriplegic cerebral palsy. An initial assessment (12/13/24) completed by Nurse N noted the resident had two infected wounds and was to receive antibiotic treatment (ABT) at the facility. The initial assessment and following Minimum Data Set (MDS) noted the resident was severely cognitively impaired and required extensive one to two person assistance with all activities of daily living. Order details (12/13/24):Order summary: Piperacillin Sod-Tazobactam .use 4.5 gram intravenously every 8 hours for infection for 7 days . *End date of 12/20/24. PMR (physician medicine and rehabilitation) progress note (12/17/24): .Patient admitted to facility on 12/13/24 .PMR consulted to evaluate rehab needs .I personally reviewed the hospital records .continues with RUE PICC for antibiotic tx of Osteomyelitis till 1/8/25 . *It should be noted there was no indication in the initial facility order (12/13/24) that the resident was to receive antibiotics until 1/8/25 (28 days). R302's MAR (medication administration record) noted the resident received the above order (Piperacillin) starting on or about 12/13/24. The antibiotic was noted to be provided through 12/20/24 (last dose at 2 PM). The MAR did not document that the medication was provided on 12/18/24 at 2PM or 12/19/24 (2 PM). Further review noted that there were no more attempts to administer the medication 12/21/24 through 12/30/24. The MAR noted attempts to administer the antibiotic on 12/31/24 at 2 PM and 10 PM with a note that indicated the medication was hold/see progress note. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235293	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Farmington	34225 Grand River Ave Farmington, MI 48335

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/31/24: Note: Piperacillin Sod-Tazobactam So Intravenous Solution .use 4.5 gram intravenously every 8 hours for Osteomyelitis for 21 days begin after picc line is placed awaiting IV to be placed in. 12/31/24: Orders Administration Note: Piperacillin Sod-Tazobactam So Intravenous Solution .Use 4.5 gram intravenously every 8 hours for Osteomyelitis for 21 days begin after picc line is placed . 1/1/25-Progress note: .unable to insert PICC line .Resident sent out to (name redacted) Hospital for PICC line insertion . (Name redacted) Hospital Records (1/1/24): .Vascular Surgery Consult .Reason for consult: IV access .Plan: when reviewing the chart patient requires another 3 weeks of IV antibiotics . On 2/4/25 at approximately 4:00 PM, an interview was conducted with Nurse N who was queried as to the facility protocol for newly admitted patients, specifically ensuring necessary medications prescribed by hospital physicians are provided to the resident(s) during their stays. Nurse N reported that upon admission nursing staff will review the hospital records, including, but not limited to medication orders. Once they review the orders they are sent to the residents treating physicians and nursing staff will place the orders in to the residents clinical records. Nurse N was asked about R302 as it appeared they had completed the initial assessment. Nurse N noted that they had been working with another Nurse (herein Nurse E) who put in R302's medication orders. Nurse N was asked if they were aware that the initial order expected the facility to provide IV antibiotics for 28 days and it appeared as the original order was only for 7 days. Nurse N noted that they were aware that there had been some confusion, and the facility tried to restart the medication again but there were some issues with the PICC line. On 2/5/25 at approximately 3:28 PM, an interview was conducted with Nurse 'E. Nurse E reported that they had been employed by the facility for about six months. When asked if they were familiar with R302, they noted that they were. When asked about entering R302's IV order antibiotic order upon their admission, Nurse E reported that they recently reprimanded by the Director of Nursing (DON). Nurse E could not provide a specific date that the DON spoke with them, but noted they were educated on double checking orders and ensuring correct orders are put in place. On 2/5/25 at approximately 1:40 PM, an interview was conducted with the DON. The DON was queried as to the failure to correctly place R302's hospital order for antibiotics. The DON replied that they were aware of the situation and had educated Nurse E. When asked as to the 10 day lapse in providing R302 with antibiotics and the concern regarding the closed PICC line, the DON again stated that Nurse 'E was reeducated. No specifics were provided as to the issue with the PICC line re-insertion. A review of the facility policy titled, Medication Administration (1/1/22) read, in part: Policy: Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .correct any discrepancies and report to nurse manager .

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on interview and record reviews the facility failed to timely review and report abnormal lab results to the Physician and/or Nurse Practitioner (NP) for one (R314) of three residents reviewed for death. Findings include: Review of the medical record revealed R314 was admitted on [DATE] with diagnoses that included: Dementia and Anemia. A review of the progress notes documented the following: A NP note (later identified as NP K) dated 12/24/24 at 3:41 PM, documented in part . recent hospitalization , d+[DATE] - 12/11 for anemia (Hgb - Hemoglobin 5.2) . received 2 units of pRBC's (packed Red Blood Cells) and IV (intravenous) iron at the hospital and gastroenterology was consulted . A Nursing note dated 1/6/25 at 11:28 AM, documented in part . order STAT (immediate) redraw if HGB is still low send to ER (emergency room) . A NP K note dated 1/6/25 at 2:16 PM, documented in part . Anemia: Hgb 6.6 on 1/3. STAT CBC (Complete Blood Count) ordered. Patient to be transferred to ED (Emergency Department) if Hgb< (less than) 7 for transfusion . A Nursing note dated 1/7/25 at 1:45 AM, documented in part . unresponsive . TOD (time of death) 0109 . This note was documented by Licensed Practical Nurse (LPN) J. Review of a lab report dated 1/6/25, documented as Reported Date: 1/6/2025 17:59 (5:29 PM) . noted a HGB of 6.415 L (low) - (reference range: 11.60-15.00). Review of the record revealed no documentation of the staff to identify the abnormal HGB range or notification to the Physician or NP. Further review revealed the resident was not sent to the hospital as directed by the NP for the low hemoglobin. A review of a facility policy titled Laboratory and Diagnostic Guidelines revised date 10/26/23, documented in part . This guideline is set up to track the timely completion, reporting and monitor of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status . The physician should be notified of all lab/diagnostic test results based on the below parameters . Critical lab results or urgent diagnostic should be called to the physician upon receipt . All notifications, attempts at notifications, and response should be noted in the resident's medical record . (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 2:26 PM, the Director of Nursing (DON) was interviewed and asked how the facility receives their lab results from their lab company. The DON stated once the labs are complete they are uploaded to the residents chart. The DON was then asked about the lab results for R314 for the date of 1/6/25 that notes it was reported to the facility at 5:29 PM. The DON was asked why R314 was not sent out per the clinicians directive as documented for the low HGB level and why there was no documentation of the Physician and/or NP to have been notified. The DON stated they would look into it and follow back up. On 2/6/25 at 2:36 PM, LPN J was interviewed via telephone and asked if they had notified the Physician or NP of R314's low hemoglobin results and LPN J stated No, they along with the nurse they received report from on 1/6/25 (dayshift nurse) had looked into the system and did not find results for the resident. LPN J stated it was not until the next day that the unit manager had showed them where the results were and how to obtain them. LPN J explained R314 had two last names (hyphenated last name). LPN J stated they along with the off going nurse on 1/6/25 looked under one of the last names and their was no result. LPN J stated the unit manager showed them where to look and obtain the results moving forward. On 2/6/25 at 2:53 PM, an attempt to contact R314's assigned Physician at the facility (Physician I) was made via telephone. A voice message was left with the number to return the call. A return phone call was not received by the end of the survey. On 2/6/25 at 3:09 PM, NP K was interviewed via telephone and was asked if they were informed of R314's abnormal HGB on 1/6/25 that required them to be transferred to the hospital as they directed and NP K stated they were not informed by the staff of the abnormal STAT HGB level. No further explanation or documentation was provided before the end of the survey.