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	10/24/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to ensure the correct resident/ legal representative signed Advanced Directives/DNR (do not resuscitate) form for one resident (R50) of one residents reviewed for advanced directives. Findings include: On 10/21/24 the medical record for R50 was reviewed and revealed the following: R50 was initially admitted to the facility on [DATE] and had diagnoses including Adult failure to thrive and Dementia. A review of R50's MDS (minimum data set) with an ARD (assessment reference date) of 8/19/24 revealed R50 needed assistance from facility staff with their activities of daily living R50's BIMS score (brief interview of mental status) was 15 indicating intact cognition. An advanced directives from signed by R50's son on 8/13/24 was reviewed that documented R50 was not to have any intubation or feeding tubes and was to have a DNR code status. Further review of the medical record did not reveal any documentation that R50 had been deemed mentally incapacitated and unable to make their own medical decisions. On 10/23/24 at approximately 12:35 p.m., Social Service worker B (SSW B) was queried regarding the advanced directives for R50 and why R50's son had signed their advanced directives instead of R50. SSW B reported that the form was completed with the previous Social Service worker. SSW B was queried if the resident had been deemed mentally incapacitated and they indicated they had not and that they would correct it by by taking a new advanced directive form to R50 and reviewing their options with them instead of their son. On 10/23/24 a facility document titled Advanced Directives was reviewed and revealed the following: 1. Prior to or upon admission of a resident to our facility, the Social Services Director or (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. 2. Each resident will also be informed that our facility ' s policies do not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive. 3. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. 4. Should the resident indicate that he or she has issued advance directives about his or her care and treatment, documentation must be recorded in the medical record of such directive and a copy of such directive must be included in the resident ' s medical record .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure feeding assistance/supervision and regular bathing were provided for three residents (R17, R20, and R174) of four residents reviewed for activities of daily living (ADL's). Findings include: R174 On 10/21/24 at approximately 9:18 a.m., R174 was observed in their room, laying in their bed. R174 was queried if they had any concerns regarding their care in the facility and they indicated they have not received any showers since being admitted to the facility and reported they did not feel clean. On 10/22/24 the medical record for R174 was reviewed and revealed the following: R174 was initially admitted to the facility on [DATE] and had diagnoses including Heart failure and Severe Calorie-protein malnutrition. A review of R174's MDS (minimum data set) with an ARD (assessment reference date) of 10/15/24 revealed R174 had a BIMS score (brief interview of mental status) of 13 indicating intact cognition. A review of R174's comprehensive plan of care revealed the following: Focus-Resident has an ADL self-care performance deficit related to generalized weakness. Date Initiated: 10/11/2024 . A review of R174's bathing (scheduled on Mondays/Thursdays) documentation revealed the following dates in which R174 was documented as having been provided bathing: 10/21 (bed bath) 10/22 (not available). No bathing documentation was provided for 10/14 or 10/17. No documentation that R174 refused any offered bathing was noted in the record. On 10/23/24 at approximately 2:14 p.m., during a conversation with the Director of Nursing (DON), the DON was queried where the Certified Nursing Assistant (CNA's) document offered bathing in the medical record and they reported that it was in the CNA task screen and that bathing should be offered twice a week. At that time, the DON was informed that R174 only had one episode of being offered bathing (10/21) and they indicated they would have to look into it. No further documentation that R174 was offered bathing twice a week per their schedule was received by the end of the survey. 47283 R17 Record review revealed R17 was admitted to the facility on [DATE] with diagnoses that included dementia, chronic respiratory failure, muscle weakness and chronic obstructive pulmonary disease. Based on the Minimum Data Set (MDS) assessment dated [DATE], revealed R17 had a Brief interview for Mental Status (BIMS) of 9/15 indicative of moderate cognitive impairment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8:55 AM, R17 was observed sitting in the dining room eating breakfast. There was another resident eating in the dining room. There were no staff members in the dining room. R17 was eating their oatmeal. An interview was completed with R17 after approximately 15 minutes. Throughout the observation no staff member came in and assisted R17. R17's breakfast tray had an unopened carton of milk and apple juice on it. When queried about their breakfast R17 reported that they did not like eggs and liked their oatmeal. When queried about the milk and juice, they reported they liked it and they would drink it but needed assistance to open the carton. R17 had a cup of coffee in a regular cup and they were drinking their coffee. Review of R17's Electronic Medical record (EMR) revealed an order dated 2/2/24 that read, regular diet-level-3 texture, regular fluid, thin consistency, needs assistance with meals. Review of R17's care plan revealed an intervention dated 9/20/23 that read, Eating- offer assistance with meal setup as needed and encourage resident to use cup with lids when handling hot liquids. There were no lids on the meal tray. R20 Record review revealed R20 was a long-term resident of the facility admitted on [DATE]. R20's admitting diagnoses included diabetes, dysphagia (difficulty swallowing), heart failure, dementia, cachexia (a condition that causes significant weight loss and muscle loss). Based on the MDS assessment dated [DATE], R20 had a BIMS score of 8/15, indicative of moderate cognitive impairment. R20 was dependent on staff assistance with their mobility and positioning. An initial observation was completed on 10/21/24 at approximately 8:55 AM. R20 was observed in the dining room with another resident. R20 was sitting up in a Geri-chair (a large, padded reclining chair used for residents with limited strength or balance and/or mobility). R20 was eating their breakfast and had an unopened carton of milk on their tray. The chair back was reclined with their legs propped up i.e. the chair was not in upright position to accommodate safety during meals. R20 had scrambled eggs and a slice of French toast. There were no staff members in the dining room during the meal. A follow-up observation was completed on 10/22/24 at approximately 8:45 AM. R20 was sitting in the dining room. R20's Geri-chair was reclined with legs propped up and they were eating breakfast. There were no staff member in the dining room. Review of R20's EMR revealed orders that included: an order dated 10/18/24 that read, Diet level 3 texture, regular fluid, thin consistency, set up support. Assist with cutting items and ST (speech therapy) evaluation complete. ST to treat 5/wk (week). x 4 weeks for increased diet tolerance, dysphagia management, and compensatory strategies. Review of R20's care plan revealed that R20 needed staff assistance with their mobility and positioning and for eating read, Supervision - offer assistance with meal setup as needed dated 8/8/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Director of Rehab (DOR) P on 10/22/24 at approximately 9:05 AM. DOR P was queried about R20 and if they were receiving skilled speech therapy services. They reported that they have been working with R20 for their swallowing management. When queried about R20's needs and what they were working on, they added that R20 was on level 3 (mechanical soft). DOR P added that the focus for R20 included upright positioning during their meals and staff supervision with verbal reminders periodically as needed to ensure that they were taking smaller bites. They added that R20 tends to take large bites and needed assistance with setting up the food and supervision for verbal cues as needed. An interview was completed with the Unit Manager (UM) E on 10/22/24 at approximately 8:55 AM in the dining room. During the interview there were no staff members in the dining room. UM E was notified of the dining room observations from 10/21/24 and 10/22/24. During this time R20 was trying to open their milk and UM E went and assisted the resident, after the concern was brought to their attention. UM E reported that they were supposed to have a staff member in the dining room to assist residents and supervise them as needed. They reported that they understood the concern. An interview was completed with Director of Nursing (DON) on 10/23/24 at approximately 10:15 AM. The DON was notified of the dining room observations from 10/21/24 and 10/22/24 for R17 and R20 and queried on expectations of the staff. The DON reported that they expect a staff member to stay in the dining room to provide supervision and assistance as needed. The DON reported that they understood the concerns. A facility provided document titled Resident Meal Service with a revision date of 1/1/22 read in part, Policy: Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service and appropriate feeding assistance. Policy Explanation and Compliance Guidelines: 1. The interdisciplinary staff, including nursing staff, the Attending Physician and the Dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits. They will develop a resident care plan based on this assessment. 2. Nursing personnel will ensure that residents are served the correct food tray. 3. Prior to serving the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident. If there is doubt, the Nurse Supervisor will check the written physician's order. 4. If an incorrect meal has been delivered, nursing staff will report it to the Food Service Manager so that a new food tray can be issued. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. To minimize the risk of foodborne illness, the time that potentially hazardous foods remain in the danger zone (41degress F to 135 degrees F) will be kept to a minimum. Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded. 6. Assistive devices will be made available to residents who need them. 7. Nursing personnel will evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. Nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition . Review of the document titled Activities of Daily Living (ADLs) with a revision date of 12/28/23 read in part: Policy: The facility takes measures to minimize the loss of residents functional abilities, including activities of daily living (ADLs). Activities of Daily Living include the ability to: 1. Bathe, dress, and groom; 2. Transfer and ambulate; 3. Toilet; 4. Eat; and 5. Use speech, language or other functional communication systems. Policy Explanation and Compliance Guidelines: 1. Conditions which may demonstrate unavoidable decline in ADLs include a. Natural progression of the resident ' s disease state with known functional decline. b. Deterioration of the resident ' s physical condition associated with the onset of a physical or mental disability while receiving care to restore or maintain functional abilities. c. Refusal of care and treatment by the resident or his/her surrogate to maintain functional abilities. 2. The facility provides maintenance and restorative program to assist residents in achieving and maintaining the highest practicable outcome based on their comprehensive assessment. 3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview and record review, the facility failed to timely assess/follow-up change in condition, obtain an order and transfer resident(s) (R275) to a hospital in a timely manner, for one of four residents sampled for hospitalization , resulting in prolonged suffering and illness with continued decline in health of the resident(s) resulting in death of one (R275) resident and hospitalization of the other (R64) resident. Findings include: R275 Record review revealed R275 was long-term resident admitted to the facility on [DATE]. R275 had a most recent hospitalization between [DATE] and they were readmitted to the facility on [DATE]. R275's admitting diagnoses included sepsis, failure to thrive, pneumonia, respiratory failure and dementia. Based on the Minimum Data Set (MDS) assessment dated [DATE], R275 had a Brief Interview for Mental Status (BIMS) score of ,d+[DATE], indicative of moderate cognitive impairment. R275 had a public guardian who was making decisions for the resident. Review of R275 advance directives (a legal document that states a resident's wish regarding medical treatment when they were unable to make their choices), dated [DATE], signed by their legal guardian revealed that they were a Full Code i.e. that they wished to receive all life sustaining measures. R275 was readmitted to the facility on [DATE] after hospitalization with pneumonia, respiratory failure and sepsis. R275's was receiving nutrition and hydration through enteral feeding administered via a PEG (Percutaneous Endoscopic Gastrostomy tube surgically placed directly placed on stomach to receive nutrition and hydration). Review of R275's vital signs and care plan revealed that they were receiving oxygen at 2 L/min (liters/minute) via nasal cannula. Review of R275's physician orders revealed an order for a chest x-ray dated [DATE] due to shortness of breath. A nursing progress note dated [DATE] at 10:08 revealed that the NP (Nurse Practitioner) for the attending physician was notified and there were no new orders. Review of the x-ray results revealed that there was questionable pneumonia or pulmonary edema (fluid build up in lungs) and the examination was limited due to positioning during the x-ray procedure. A practitioner note dated [DATE] revealed R275 was seen for anxiety and restlessness and it read Spo2 (oxygen saturation) was in the high 80's and low 90s, patient restless, she was given Xanax 0.5 mg (milligram), it was effective .SpO2 (pulse oximetry) improves to the 90s. Further review of the progress notes did not reveal any follow up by the practitioner or physician after [DATE], when nursing staff had communicated the x-ray results to the nurse practitioner (NP) Q. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the form titled SBAR (Situation-Background-Assessment-Request) communication and progress note dated [DATE] at 7:30 AM revealed that the decline/change in condition started on [DATE]. R275 had a respiratory rate of 30 breaths/minute with a heart rate of 109 bpm (beats per minute). The note read, Increased O2 from 2 L/min (liters/minute) (at 89%) to 6 L/min. humidified ,d+[DATE]% and R275 had a tan color emesis (vomiting) at 6:00 AM. The assessment also revealed that R275's breathing was labored and was identified as positive for sepsis (life-threatening medical emergency that occurs when the body has an extreme response to an infection). The nursing assessment also revealed that R275 was possibly experiencing respiratory or gastrointestinal problems. Review of the change of condition assessment revealed that based on the nursing assessment, recommendations included transfer to hospital. The notification section to primary care clinician revealed that the nurse had left messages for the attending physician and the nurse practitioner. R275 expired at the facility on [DATE] at 12:54 PM. Review of the form titled change of condition/return to hospital risk dated [DATE] at 7:33 AM revealed the nurse had contacted the attending physician and practitioner and had left messages and waiting for a call back. There was no evidence that the attending physician/practitioner had followed up timely. Review of vital sign report revealed that O2 was changed from 2 l/min to 6l/min on [DATE] at 23:45 (11:45 PM), but there was no physician order. Review of R275's Electronic Medical Record (EMR) revealed a nursing progress note dated [DATE], at 16:20 (4:20 PM) revealed in part, Writer received in report that resident exhibited signs of reduced oxygen. Midnight nurse reported they increased oxygen liters from 2L to 6L. Post report writer into room to assess resident's condition; resident alert and responding to verbal and tactile stimuli. Resident displayed no signs of acute respiratory distress or discomfort at the time. Writer obtained vital signs and vitals noted at BP (blood pressure); ,d+[DATE]; HR (heart rate)111; SPO2 94% on 6L of O2; Temp 97.6; and RR (respiratory rate) 18 bpm (beats per minute). Writer then contacted MD (Medical Doctor) of condition and received no response at that time. Writer then administered all scheduled meds and treatments and resident's baseline remained the same. At 12 noon, writer doing hourly rounds noted the resident unresponsive. Writer called code and began compressions at .911 was called. Staff continued with rounds of CPR (cardiopulmonary resuscitation) while awaiting Fire Department and Police arrival. Staff had done four rounds of CPR by the time 911 emergency arrived. At 12:17pm the fire department and police arrived at the scene. At 12:17 pm Fire Department began their runs. 12:25pm IV (intravenous) initiated and started on the resident and at 12:27 pm first round of epinephrine administered. 12:30 pm the resident was incubated. At 12:34 pm, second round of epinephrine administered. 12:35 pm a third round of epinephrine was administered. At 12:37pm pulse check done; and no pulse was palpable. 12:38 pm a fourth round of epinephrine was administered. At 12:43pm a fifth round of epinephrine administered and a sixth round of epinephrine administered at 12:46 pm. At 12:48pm resident checked for a pulse; no pulse palpable. 12:49 pm a seventh dose of epinephrine administered. At 12:51 pm; resident checked for pulse; no pulse palpable. At 12:54 pm the time of expiration called . An initial interview was completed with Nurse Practitioner (NP) Q on [DATE] at 12:34 PM. During the interview they were queried that if they had received calls from the facility regarding R275's change in condition and if they had followed up. They reported they knew that R275 had expired and they were not able to recall if they had received any calls; they would check their voicemail and they would get back. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview was completed with NP Q on [DATE] at 2:28 PM and 2:39 PM. During the interview the practitioner reported they received the voicemail on the weekend on [DATE] around 12 AM and they did not get the message until later when they had found out R275 had passed. The practitioner Q was queried how they had covered after hours or weekend calls. NP Q reported they regularly rounded the facility on weekdays and staff would have to contact the medical director if they were not able to get in touch with the attending physician. They did not provide any further explanation. An initial interview with Director of Nursing (DON) was completed on [DATE] at approximately 1:15 PM. The DON was queried about R275 and their change of condition and their expectations with the staff follow up. The DON reported that they were aware of the situation and it happened over a weekend. They reported that the nurses had completed a timely assessment and shared the SBAR assessment and added that the physician ordered to increase the O2 from 2L/min to 6l/min and the nurse failed to transcribe the order. During a follow-up interview with the DON on [DATE] at approximately 2:35 PM, they were queried about the staff and physician timely follow up after the identified change of condition from [DATE] midnight shift to [DATE], 12 noon when R275 was observed unresponsive. The DON reported that staff should contacted the medical director if they were not able to get in touch with the attending physician and in this case R275 was a full code and they should have transferred the resident out to the hospital. They were notified of the concern and they reported that they understood the concern.

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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** 47283 Based on observation, interview and record review facility failed to implement range of motion/splinting interventions for two (R4 and R43) of two residents with contractures reviewed for positioning/range of motion resulting in the potential for extreme pain, discomfort, and worsening of contractures. Findings include: R4 Record review revealed that R4 was a long-term resident admitted to the facility on [DATE]. R4's admitting diagnoses included head injury, encephalopathy, seizures, and history of right knee pain. Based on the Minimum Data Set (MDS) assessment dated [DATE], R4 had a Brief Interview for Mental Status (BIMS) of 0/15, indicative of severe cognitive impairment. R4 needed substantial assistance from staff with her Activities of Daily Living (ADLs) and mobility. The MDS assessment also revealed that R4 had limited range of motion in both lower extremities. An initial observation was completed on 10/21/24 at approximately 10:55 AM. R4 was observed in their bed, lying on their back with their eyes closed. Both knees were pulled up (bent) with feet resting on their bed. R4 did not respond when called their name. A Geri-chair (a padded reclining chair with wheel used for patients with limited mobility, range of motion, impaired trunk control, etc.) was inside the room and an assigned staff member explained the chair was for R4. Later that day multiple follow-up observations were completed at approximately 1:15 PM, 3:30 PM, and 4:15 PM. R4 was observed in bed with their knees bent and eyes closed. On 10/22/24 observations were completed at approximately 8:45 AM, and 11:30 AM. R4 was observed in their bed lying on their back, with both knees bent. R4 stayed in their bed throughout the day during these observations. R4 was unable to respond to any questions. Review of R4's Electronic Medical Record (EMR) revealed an order dated 10/7/23 that read Baclofen oral tablet 10 milligrams for muscle spasms. Review of R4's care plan revealed a focus area that read Resident has an impaired musculoskeletal status related to bilateral knee contractures. Review of the interventions for the knee contractures revealed no restorative /maintenance interventions for both lower extremities to prevent worsening of contractures. Further review of physician orders and Certified Nursing Assistant (CNA) task list did not reveal any range of motion/maintenance program. Review of the facility provided document titled Range of Motion Evaluation Chart revealed on Page 2 of the document, that read attempted to range but patient resisting with no other specifics on a plan and did not have any name or credentials of the clinician. An interview was completed with the Director of Rehab (DOR) P on 10/21/24 at approximately 4:15 PM. During the interview the DOR P reported that R4 was not receiving any skilled services currently and they were due for an annual range of motion assessment. The DOR P reported that the facility had a restorative program and they were unsure of R4 was on a restorative/maintenance program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at approximatley 10:40 AM, an interview was completed with the Unit Manager (UM) E (for the unit where R4 was residing) who was also overseeing the restorative nursing program. During the interview UM E was queried about the restorative program and how they had determined which residents qualified for the restorative/nursing maintenance program. They reported that they recently took over the program and they were based on referral from physical/occupational therapy services. They added that the restorative team was managing all residents with splints or devices. When queried if they had R4 on any restorative/maintenance program for their lower extremity contractures, they reported that R4 was not receiving services. UM E was queried and they reported that they were not sure why they were not receiving any services and that R4 would benefit with services. They were notified of the concern and they reported that they understood the concern and they would address it. An interview was completed with the Director of Nursing (DON) on 10/23/24 at approximately 10:30 AM. The DON was notified of the concerns with maintenance/restorative program for R4 and the follow up with UM E. They reported that they understood the concern and agreed that R4 should have been on a range of motion program and added that they would have their team address the concern. A review of the facility policy titled Range of Motion with a revision date of 10/21/24, read in part, Policy: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. Definitions: Range of Motion means the full movement potential of a joint. Policy Explanation and Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care. 2. Assessment for Range of Motion: a. The resident's range of motion (such as current extent of movement of his/her joints and the identification of limitations) shall assess on admission/readmission, quarterly, and upon a significant change. b. Residents who exhibit limitations in range of motion, initially and thereafter, shall refer to the therapy department for a focused assessment of range of motion and/or restorative nursing program. c. Nursing assistants will report any significant changes in range of motion, as noted during daily care activities, to the resident's nurse when any changes are noted. 3. Care Planning a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes but is not limited to: i. Appropriate services (specialized rehabilitation, restorative, maintenance). (continued on next page)

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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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Appropriate equipment (braces or splints). iii. Assistance as needed (active assisted, passive, supervision) . 41415 R43 On 10/21/24 at 9:26 AM, R43 was observed lying on their back in bed. Enteral feeding was observed infusing via gastrostomy tube and both the left and right hands were observed contracted. No device or padding was observed in the palms of R43's hands. Review of the medical record revealed R43 was initially admitted to the facility on [DATE] with a readmitted [DATE] and diagnoses that included: acute respiratory failure with hypoxia, quadriplegia, and contracture of muscle to the left and right upper arms. Review of the Physician orders and care plans revealed no implemented plan of care for R43's hand contractures. Review of a Physical Medicine Rehabilitation (PMR) follow up note dated 9/25/24 at 8:17 PM, documented in part . CHIEF COMPLAINT: Mobility and ADL (assistant daily living) dysfunction secondary to respiratory failure . Patient seen and examined. Patient observed in bed with eyes wondering . She has a rolled wash cloth in hand, tight hand contractures noted. Patient has trach (tracheostomy) and is ventilator dependent. She does not appear to be in any pain . ASSESSMENT/PLAN . OT (occupational therapy) will work on ADL and functional mobility training and hygiene. PT (physical therapy) will work on strengthening . Manual Tx (treatment): stretching of shortened connective tissue to hands, elbow jts (joints) and shldrs (shoulders). Noted to nsg (nursing) to having yeast growing at elbow jts . Contracture . b/l (bilateral) hand contractures . to use rag rolls for hands to help with hand hygiene. Hands are too tight for hand splints . Review of the medical record revealed no intervention implemented for the rag rolls for R43's right and left hand contractures. On 10/22/24 at 10:22 AM, Therapy Director (TD) M was interviewed and asked to provide all PT and OT evaluations and encounters for R43. Review of the Therapy documents provided revealed no documentation addressing or implementing the PMR practitioners note on 9/25/24. Further review of the therapy documentation revealed no identification or plan of care for R43's bilateral hand contractures. On 10/23/24 at 11:30 AM, TD M was interviewed and asked who's responsible to review the plan of care documented by the PMR clinician and asked about the PMR plan of care documented on the 9/25/24 consult. TD M stated they recently talked with the PMR clinician and addressed a few of their concerns, one being that the PMR clinician would write recommendations on their consults without informing the therapy team. No further explanation or documentation was provided by the end of the survey.

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on interviews and record reviews the facility failed to ensure residents that required Ventilator care were provided ongoing medical supervision and oversight by a Physician for their respiratory care, ventilator and/or tracheostomy care, including the weaning process for ventilator residents, respiratory examinations, assessments and respiratory/ventilator changes in status throughout their inpatient stay, for nine (R's 40, 30, 55, 57, 35, 41, 10, 19 & 42) of 15 residents reviewed for ventilator care resulting in an identified systemic failure of interdisciplinary approach and Physician oversight for residents that required Ventilator and respiratory care, including adequate implementation of policies and procedures to monitor and supervise the weaning process for mechanical ventilation, and responding to mechanical ventilation alarms and respiratory needs, which resulted in the increased likelihood of serious harm, serious injury and/or death to occur. Findings include: The Immediate Jeopardy (IJ) was identified on [DATE] at 11:51 AM. The IJ began on [DATE]. The Administrator and Ventilator Unit Administrator A was notified of the IJ on [DATE] at 1:34 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 patterned 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). R40 Review of a closed record death at the facility for R40 revealed the following: R40 was admitted to the facility on [DATE] and expired in the facility less than a month later on [DATE]. Admitting diagnoses included: acute and chronic respiratory failure, epilepsy and epileptic syndromes, history of sudden cardiac arrest, acute systolic congestive heart failure, atrial fibrillation, hemiplegia/hemiparesis affecting right dominant side, tracheostomy status, gastrostomy status and ventilator dependent. Review of the progress notes revealed the following for the date of [DATE]: A Respiratory Note (RT) at 9:00 AM, documented in part . Per protocol, placed pt (patient) on CPAP (continuous positive airway pressure) /PSV (pressure support ventilation) vent mode; appeared to be tolerating wean . [NAME] (no apparent respiratory distress) noted. Will con't (continue) to monitor resp (respiratory) status. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A RT note at 7:06 PM, documented in part . patient received from previous shift, non-verbal, non-focused response, moderately diminished gag/cough reflex, oral, nasal and tracheal secretions suctioned in moderate to large amounts, patient not tolerating PSV vent settings and change to AC (assist control) due to persistent low minute volume alarms, low RR (respiratory rate), grayish facial skin, slightly diaphoretic, will continue to monitor. A Nursing note at 10:44 PM, documented in part . At 2244 (10:44 PM), found to have no pulse. Chest compressions started and also bagged with full support. Patient already traced and vented. 911 in and used thumper machine. Seven does <sic> of epinephrine used. Patient underlying rhythm asystole. Patient pronounc <sic> 2326 (11:26 PM). Patient's daughter notified and came up to the facility. Patient medical service and DON (Director of Nursing) called about event . Review of a policy titled Ventilator Unit- Weaning protocols for the mechanically ventilated patient revised on [DATE], documented in part . Purpose - To facilitate the liberation of patients from mechanical ventilation and provide a consistent approach to the ventilator weaning process. This pathway is a collaborative plan mean to guide the care of ventilator patients. It may be modified based on clinical indication, if appropriate and documented, or in emergency situations . Weaning from mechanical ventilation will be initiated with a physician's order only. Nurses and Respiratory Therapists will be responsible for the care of eligible residents . The ventilator weaning protocol will be implemented following the order of a physician. Eligibility for ventilator liberation will be assessed daily through a collaborative evaluation between respiratory therapy and nursing . Mechanical ventilator weaning will be initiated if: 1. The physician concurs that the patient's condition is consistent with weaning and is clinically stable. 2. The physician may write weaning parameter orders. 3. A pulse oximeter will be utilized on all patients to follow specifically ordered weaning parameters. 4. If at any time the patient develops respiratory distress, or does not tolerate the weaning procedure, returning the patient to safe acceptable ventilator settings and notify the physician. Review of R40's medical record revealed no assessments/evaluations documented by a physician to determine if R40's condition was clinically stable and was eligible for weaning, no weaning parameter orders/protocol, no ongoing pulse oximeter readings documented during the weaning process and no documentation of notification to the physician once R40 was identified to have a change of condition. There was also no identified ongoing nursing assessments documented in the residents record after the identified change of condition. The record revealed no physician order implemented for Pressure Support Ventilation to start the weaning process for R40. Further review of the medical record revealed no examinations/evaluations completed by the facility's Pulmonologist or Physician regarding their ventilator and respiratory care. On [DATE] at 3:39 PM, a telephone interview was attempted with Registered Nurse (RN) G (the nurses assigned to R40 the evening they expired in the facility) and a message was left for RN G to return the call. On [DATE] at 3:31 PM, a telephone interview was attempted with Respiratory Therapist (RT) H (the evening RT who provided care to R40 on [DATE]) and a message was left for RT H to return the call. On [DATE] at 8:32 AM, a second attempt for a telephone interview with RT H was unsuccessful. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:20 AM, an interview was conducted with the Respiratory Therapy Director (RTD) I. RTD I was asked if they were aware of R40's change of condition on [DATE] and the physician to not have been notified. RTD I stated they talked to RT H because they had worked the night shift and they questioned RT H about the incident on [DATE]. RTD I stated RT H found that R40 was not tolerating the weaning process and that R40 was not breathing well. RTD I stated RT H then stated they put R40 back on full ventilator support. RTD I stated that RT H verbalized R40's nurse being in the room at the time, so they did not feel the need to chart any more or contact the physician. RTD I stated they educated RT H at . length about documentation and the importance of making sure it's in the medical record. RTD I was asked the facility's protocol on weaning, due to the review of R40's medical record revealed no documentation of the weaning protocol they utilized on [DATE]. RTD I stated . It's a little vague on the weaning . but stated they will find the sheet that they use. On [DATE] at 12:27 PM, the primary Physician for R40, (Physician J) was interviewed via telephone and asked if they had been notified of R40's change of condition after the unsuccessful weaning process on [DATE] and Physician J stated they were not notified. On [DATE] at 2:36 PM, RN G returned the call and was interviewed. RN G was asked about [DATE] and the events leading up to R40 being found unresponsive. RN G stated R40 was not tolerating the weaning because the alarm (on the ventilator) was going off consistently. RN G stated they informed RT H that R40 was not tolerating the weaning process and needed to go back on full support. RN G stated they did not have any other issues with R40 until they were found unresponsive. RN G was asked the facility's monitoring process for a resident who was identified with a change of condition after an unsuccessful weaning attempt and RN G stated they never seen a protocol in place to wean a person. RN G stated that R40 was in pretty bad shape and prognosis was poor prior to the attempted wean. RN G was then asked who decided that R40 was an eligible candidate to wean if they were in such bad shape and RN G stated they were not sure. RN G denied being informed of R40 to have been grayish in color and diaphoretic as noted by RT H. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 4:07 PM, RT H returned the call and was interviewed regarding R40 on the date of [DATE]. RT H stated at the start of their shift they had received report from the off going RT who stated R40 was being weaned and was tolerating the wean. RT H stated the off going RT instructed RT H to leave R40 on their current weaning settings throughout the night since they were tolerating the wean. RT H stated R40 was comatose and didn't move. RT H was asked who decided R40 was an eligible candidate to wean and RT H stated they were not sure. RT H stated RN G informed them of R40's vent alarms continuously going off and that they were not tolerating the wean. RT H stated the ventilator alarms were going off and the resident was not looking good and was diaphoretic and they had never seen the resident like that before. RT H stated they put R40 back on full ventilator support. RT H stated that RN G was aware of R40's change of condition. RT H stated in part . he was only breathing 8 (respiration rate) per minute and this patient usually is in the 20's and 30's and he was 8 because the air is not getting through to him . RT H stated they work night shift in the facility and would usually not wean the residents at night due to the fact that they weaned during the day and needed to rest and recuperate throughout the night. RT H stated they did not have any other interactions with R40 until they were notified of the code called for R40 due to being unresponsive. RT H was asked where the weaning protocol or order could be found for R40 and RT H stated . I already pointed it out numerous times that it should be a doctor's order to do it . RT H went on to say that they verbally communicate the orders and . there is no order so I have to do what I see fit and he (R40) was not tolerating it (wean) so I changed him (back to full ventilator support) . RT H stated they responded to the code, R40 was identified with a lot of vomit and they suctioned them. RT H stated R40 did not have a gag reflex and vitals were absent. RT H stated that's when the nurses came in to do CPR (Cardiopulmonary Resuscitation). RT H stated the facility initiates standard orders to wean residents when they are admitted , however felt it was . a big thing . that an ordered weaning protocol was not in place. RT H stated at one point of time the facility did have a weaning protocol in place. RT H stated usually a person being weaned would be done under observation and monitoring with the right equipment. RT H stated they are not getting a true picture of the residents oxygenation levels because of the lack of monitoring implemented for the residents they are weaning. RT H stated . when you are weaning someone they are able to breathe on their own but the machine ventilator was giving him (R40) his breaths. I didn't see orders so I'm basically on my own . this was an emergency . As far as I'm concerned we didn't have to call our primary or pulmonary (physician) and there was no order and we really don't call them unless the resident is being sent out (to the hospital) . They should really do trial runs on people (for weaning eligibility) but whoever is being told to do the weaning protocols they supposedly chart on it and let them run for a whole 12 hours . RT H denied informing the Physician or Pulmonologist of R40's change of condition. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 4:48 PM, the RTD I was recalled for a second interview and asked how often the facility's Pulmonologist completes their evaluations/assessments on ventilator residents. RTD I stated Not frequent. That's why I've been trying to get it changed . Everyday we do a weaning protocol with our residents. We still try them no matter what. If they are tolerating the wean we would wean by protocol . RTD I was asked a second time for the weaning protocol due to none being found in the medical record for R40. RTD I stated they were doing a slow wean because his (R40) acuity . RTD I was asked how they decided that R40 was eligible to wean since their acuity and prognosis was poor as stated by their staff. RTD I stated every vent resident has an as needed order implemented to wean. When asked for the examinations/evaluation from the physician that determined the residents to be an eligible candidate to wean, RTD I replied the Pulmonologist for the facility does not come often enough. RTD I stated . the vagueness with this policy is what bothers me . in reference to the weaning protocol. RTD I stated the Pulmonologist has never charted their examinations or assessments. RTD I stated they will sometimes reach out to the Pulmonologist for concerns with no response. RTD I stated they completed an audit of all the ventilator residents to ensure the trach supplies, ambu bag and ventilator settings matched the orders and found that most of the settings did not match the physician orders. RTD I stated the Pulmonologist will not address anything regarding the care of residents with a tracheostomy. On [DATE] at 5:21 PM, a second interview was conducted with R40's primary Physician J and Physician J was asked if they assess or examined R40's respiratory care, ventilator care/settings and eligibility for weaning and Physician J stated No, that's the pulmonologist, they come weekly. Physician J stated the Pulmonologist handles that, not them. Review of the Pulmonologist contract with the facility revealed the following: On [DATE] Pulmonologist K signed a contract that documented in part, . the facility desires to avail itself of the services of the physician as the Pulmonologist of the facility . The Pulmonologist is licensed to practice medicine in the State where the facility is located . and agreement set forth herein, the Parties agree as follows . The Pulmonologist shall provide oversight for the Facility's Respiratory Unit as follows . Conduct weekly visits and review individual respiratory residents' care plans with the Unit Manager and Respiratory Staff . Review and approve policies specific to the Respiratory Unit . Provide care for tracheostomy and vent patients, and consult on equipment needs . Provide education, as needed, to facility staff, upon request of the Administrator of the Facility . Consult with Facility Staff on changes in status and other resident needs . Due to the identified concern with R40's care the survey team expanded the sample and reviewed additional medical records of ventilator residents. The team identified no documentation in any of the ventilator resident records from Pulmonologist K. Review of a typed Ventilator Weaning Protocol . Ventilator Discontinuance/Trach Weaning/Capping Trials (undated) that was provided by RTD I revealed no documentation of it to have been reviewed by a Physician or Pulmonologist K. The typed protocol was not found to be implemented in any of the medical records of the residents dependent on the Ventilators. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 8:54 AM, Pulmonologist K was interviewed and asked if they were the contracted Pulmonologist for the facility and Pulmonologist K explained they were not contracted with the facility and operated independently. Pulmonologist K was asked how often they come to the facility to assess/examine the residents and Pulmonologist K' stated every two to three weeks. Pulmonologist K was asked where they documented their assessments and examinations and Pulmonologist K stated they document their notes in the medical record. Pulmonologist K was informed that the survey team was unable to identify any consultations, exams or assessments in any of the ventilator dependent residents for the last year and Pulmonologist K stated they had access to the facility's electronic medical system and input their notes in the system. Pulmonologist K was asked their involvement in identifying eligible candidates to wean off ventilators and stated the facility had a protocol for weaning and if they have difficulty they would discuss it. Pulmonologist K was asked if the residents being weaned should be monitored and documented continuously during the weaning process and Pulmonologist K stated Yes. Pulmonologist K stated in part . It's not safe to wean residents sometimes . Pulmonologist K was asked if they were informed of R40's unsuccessful wean and change of condition on [DATE] and Pulmonologist K stated they were not familiar with R40 and denied being notified on [DATE]. Pulmonologist K stated usually the residents are weaned during the day and put back on full support at night which is the safest way. When asked how the vent settings are determined for each ventilator resident, Pulmonologist K stated the facility follows the vent settings from their admission. Pulmonologist K was asked the expectations of the staff if a ventilator resident condition changed and needed modifications to their ventilator settings and Pulmonologist K stated the facility has a protocol for modifications for the resident ventilators. On [DATE] at 9:20 AM, the Administrator and Ventilator Unit Administrator A was asked to provide the policies for Ventilator care/management, Tracheostomy care/management, pulmonologist visits, ventilator settings protocol & ventilator weaning protocol. A policy was not provided regarding ventilator settings and the ventilator weaning protocol is documented in full as noted above, which does not contain parameters or a protocol for the weaning process. On [DATE] at 9:21 AM, the facility's Medical Director (MD) L was interviewed via telephone and asked their involvement in the respiratory care for the facility's ventilator residents. MD L stated they had nothing to do with the respiratory care for the ventilator residents. MD L stated the facility has a Pulmonologist to take care of the respiratory care, however, knew the facility was having a lot of problems with the current Pulmonologist. MD L denied ensuring collaboration of respiratory care was being provided to the mechanical ventilator residents and stated in part . I don't do anything with them, my role is not to run different parties . On [DATE] at 11:45 AM, the Administrator and Vent Unit Administrator A were interviewed and informed of the concern regarding the lack of Physician oversight, monitoring and supervision of respiratory care for residents that required mechanical ventilators. The Administrator and Vent Unit Administrator A was asked to provide all Physician documentation regarding the respiratory care, assessments and evaluations for all of the residents that required mechanically ventilation. At 1:34 PM, the Administrator and Vent Unit Administrator returned and stated they were unable to provide any documentation completed by the Pulmonologist K or provide documentation of Physician oversight regarding the respiratory care for the ventilator dependent residents. The Administrator stated Pulmonologist K would be in the facility later in the evening to provide the facility with their documentation. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at approximately 2:50 PM, the exit conference was conducted with the facility's Administration team and Corporate staff. Corporate Personnel (CP) F stated the facility had identified the concerns with the Physician services and had plans on fixing it, however they failed to address it in time and now are forced to look into it and change their system. On [DATE] at approximately 3:00 PM, Pulmonologist K approached the survey team in the parking lot of the facility and asked what documentation the State Agency was looking for. Pulmonologist K was informed that all assessments, evaluations, collaboration with care, weaning protocols should be identified in each residents record. Pulmonologist K asked if it was too late to provide the documentation and Pulmonologist K was referred to consult with the facility's Administration team. No further information or documentation was provided by the end of the survey. 38271 R10 On [DATE] the medical record for R10 was reviewed and revealed the following: R10 was initially admitted to the facility on [DATE] and had diagnoses including Chronic respiratory failure with hypoxia and Dependence on respirator ventilator status. Further review of R10's medical record revealed Physician's orders that indicated the following: Vent settings: PCV (pressure controlled ventilation) Targeted Vt (volume targeted), PIP 30 (Peak inspiratory pressure) (Vt 450ml), RR (respiratory rate) 14, PEEP 5 (Positive end-expiratory pressure) A second Physician's order dated [DATE] revealed the following: [Name of pulmonologist] to consult and participate in care. R41 On [DATE] the medical record for R41 was reviewed and revealed the following: R41 was initially admitted to the facility on [DATE] and had diagnoses including Chronic respiratory failure with hypoxia and Dependence on respirator ventilator status. Further review of R41's medical record revealed Physician's orders that indicated the following: Settings: Mode: AC (assistive control) RR:16 PEEP:5 Vt 450 A second Physician's order dated [DATE] revealed the following: Evaluation/Assessment of resident on ventilator . R55 On [DATE] the medical record for R55 was reviewed and revealed the following: R55 was initially admitted to the facility on [DATE] and had diagnoses including Chronic respiratory failure with hypoxia. Further review of R55's medical record revealed Physician's orders that indicated the following: Settings: AC 18, 450, Peep+5 every 12 hours (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A second Physician's order dated [DATE] revealed the following: Evaluation/Assessment of resident on (Ventilator) as needed . R57 On [DATE] the medical record for R57 was reviewed and revealed the following: R57 was initially admitted to the facility on [DATE] and had diagnoses including Chronic respiratory failure with hypoxia. Further review of R57's medical record revealed Physician's orders that indicated the following: Settings: Mode: A/C RR: 14 PEEP: 5 VT 450ml On [DATE] at approximately 1:37 p.m., the facility Administrator and Ventilator Unit Administrator, were queired if they were able to provide any documentation from the facility contracted pulmonologist that indicated R10, R41, R55 and R57 had been assessed/evaluated by them for ongoing respiratory/ventilator care at all during their stay in the facility and they reported they could not. 47283 R30 Record review revealed R30 was a long-term resident admitted to the facility on [DATE]. R30's admitting diagnoses included acute and chronic respiratory failure, anoxic (lack of oxygen) brain damage, and quadriplegia (paralysis of both upper and lower extremities). Review of R30's clinical record revealed that they were on ventilator, under pressure-controlled ventilation (a mechanical ventilation technique that uses a set pressure to inflate a patient's lungs). Further review of the medical record revealed no examinations/evaluations completed by the facility's Pulmonologist or Physician regarding their ventilator and respiratory care since [DATE]. R19 Record review revealed R19 was a long-term resident of the facility, admitted on [DATE]. R19's admitting diagnoses included dependence on a ventilator/respirator due to respiratory failure, chronic obstructive pulmonary disease (COPD), cirrhosis of liver, and malnutrition. Review of R19's clinical record revealed that they were on ventilator, under assist control (AC) ventilation setting (the ventilator setting that delivers a set volume of air to the patient's lungs at a set rate, either when the patient breathes or at fixed intervals). Further review of the medical record revealed no examinations/evaluations completed by the facility's Pulmonologist or Physician regarding their ventilator and respiratory care since [DATE]. R42 Record review revealed R42 was a long-term, ventilator dependent resident of the facility. They were admitted to the facility on [DATE]. R42's admitting diagnoses included chronic respiratory failure, cardiac arrest, anoxic brain damage, and dependence on ventilator. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R42's clinical record revealed that they were on ventilator, under pressure-controlled ventilation (PCV - a mechanical ventilation technique that uses a set pressure to inflate a patient's lungs). Further review of the medical record revealed no examinations/evaluations completed by the facility's Pulmonologist or Physician regarding their ventilator and respiratory care since [DATE]. R35 Record review revealed R35 was a long-term, ventilator dependent resident of the facility. They were admitted to the facility on [DATE]. R35's admitting diagnoses included bone marrow failure syndrome, respiratory failure, diabetes, and COPD. Review of R35's clinical record revealed that they were on ventilator, under pressure-controlled ventilation (PCV - a mechanical ventilation technique that uses a set pressure to inflate a patient's lungs). Further review of the medical record revealed no examinations/evaluations completed by the facility's Pulmonologist or Physician regarding their ventilator and respiratory care since [DATE]. An interview with Nurse Practitioner (NP) T was completed on [DATE]. During the interview they were queried if they were overseeing the care for ventilator dependent residents and they reported that they were only overseeing residents who were assigned to the medical director. They were queried about the ventilator settings and coordination of care with the pulmonologist for ventilator dependent residents. NP T reported that they did not handle that and they were only coordinating the care with the attending physician who was also the Medical Dierctor. The Administrator (NHA) submitted the following accepted removal plan on [DATE] at 5:53 PM: Identification of Residents Affected or Likely to be affected: All residents with ventilator assistance. The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: [DATE]) The NHA notified the Medical Director of the incident. The Pulmonologist will complete physical assessments on all like residents to identify any changes in condition and confirm current ventilator settings on [DATE] The Pulmonologist has received education outlining responsibility for oversight for respiratory care for all Ventilator residents including but not limited to o Completing physical assessments o Monitoring ongoing care o Documenting consultations/evaluations o Providing orders for weaning for ventilator residents (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The pulmonologist has agreed to round for the residents on the ventilator unit at least 2 times per week. She is available to take call 24 hours in coordination with Primary Care Provider. Ventilator orders sets are entered on admission. o Oxygen: RUN @ []L/MIN VIA []N/C []MASK []TRACH[] HOURS PER DAY [] PRN [] CONTINUOUS o Assess stoma site and under trach collar o Trach Change. Trach brand: Trach size: o Change trach collar/strap every 3 days and prn o Visual check of ventilator dependent residents per care plan and prn. o Weaning prn, per physician order, or respiratory protocol o Enter time in minutes to complete airway equipment management task o Evaluation/Assessment of resident on (Vent/Tracheostomy) o Oxygen saturation q shift and prn o Oxygen tubing/filter change every week. Enter time in minutes to complete task o Suction tracheostomy as needed o Resident/Resident Representative Education o Trach Care PRN (as needed) o Trach tie change with baths and as needed o Settings: Mode: RR: PEEP: PS: o Change circuits monthly and PRN. Enter time in minutes to complete circuit change task. o Trach care every shift and as needed

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47283 Based on observation, interview, and record review the facility failed to ensure sufficient staffing for one resident (R274) of one reviewed for staffing needs, resulting in the potential for unmet care needs of residents who reside in the facility. Findings include: R274 Record review revealed R274 was admitted to the facility on [DATE] with diagnoses including heart failure, atrial fibrillation and Chronic Obstructive Pulmonary Disease. R274 had a recent hospitalization and they were admitted to the facility for skilled nursing and rehabilitation needs. An initial observation was completed on 10/22/24 at approximately 8:20 AM. R274 had their call light on and this surveyor was walking down the hallway. R274 waved and called this surveyor and asked if they could assist. R274 was sitting on their bed and reported that they had been waiting for someone to help them and it had been a while and appeared upset. When queried further they reported, That light (call light) doesn't mean anything. A staff member (Certified Nursing Assistant - CNA) was in the hallway passing water and they were notified by the nurse to go in to assist R274. Later that day at approximately 12:20 PM a follow up interview was completed. During the interview R274 reported that they had been in the facility for a few days. When queried about the staff assistance and call light response they reported that the responses are slow in general and it took longer at nighttime. When queried about the time frame, R274 reported that it took over an hour and stated it just happened this morning. An interview was completed with a Certified Nursing Assistant (CNA) X on 10/2/24 at approximately 10:55 AM. They were queried about facility staffing. CNA X reported that the facility had hired a lot of new staff recently. When queried if they were able to meet the needs of all their residents timely they reported that they do their best as they covered both hallways. They added they covered part of the hallway from 107-114 and then the other side of the hall. They added that this hallway (with rooms 101-106) had 2 CNAs and they were 2 CNA's to cover the other hallway as well (from rooms 107-114). CNA X further explained that even though the other hallway had fewer residents, they get tied up down this hallway as almost 50% of the residents in the hallway needed 2-person assistance and they needed to stay and assist the other CNA. They added it gets harder if they were assisting with showers as it may take longer. When queried who would assist the residents on the other hallway, they reported that the nurse would have to assist and go to back and forth between both hallways. They added most of the times they were tied up on this side of the hall. When queried about nurses having their own responsibilities they stated that they are doing the best they can to meet the needs of their residents. When asked what would help, they added that may be having another CNA assist for part of the shift would help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with LPN Y on 10/22/24 at approximately 1:45 PM. They were queried about the staffing to meet the needs of all their residents. They added that lot of residents in this hall needed extensive staff assistance and they would help the CNAs on the floor because the staff needed that help. They agreed it was hard for the CNAs to complete the tasks if the nurses were not able to assist them. An interview was completed with the staffing coordinator (SC) Z on 10/23/24 at approximately 9:55 AM. They reported that they had been in that role for 6 months. They reported that they had many new staff members and had few open positions. When queried about their weekend staffing, they reported that it had gotten better in the last 3 months. When queried about the staffing prior to June, they reported that it was challenge prior to June. An interview was completed with Director of Nursing (DON) on 10/23/24 at approximately 10:30 AM. They were queried about the staffing and they agreed it was a challenge prior and it had gotten better in the last few months. They added that they were trying to have additional staff to cover call offs. Review of the facility submitted staffing report to Centers for Medicare and Medicaid Services for the period of 4/1/24 to 6/30/24 revealed that facility had excessively low weekend staffing. Review of the facility assessment with a revision date of 5/1/24 revealed that facility's nursing assistants staffing ratio will be based on the residents acuity/care needs. 38271 On 10/21/24 at approximately 4:11 p.m., during the anonymous group meeting, the group was queried regarding the staffing levels in the the facility and one resident reported that weekends call button answering was still not good and that the weekend staffing levels are low. They also reported that there are excessive call off's from the weekend staff and the facility does not fill the holes in the schedule. On 10/21/24, a review of the resident council minutes revealed the following complaints related to staffing: May 2024-Showers, water not being received consistently. October 2024-Consistency in passing water on every shift.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure non-pharmacological interventions were attempted prior to PRN (as needed) psychotropic mediation administration for one resident (R68) of five residents reviewed for unnecessary psychotropic medications. Findings include: On 10/21/24 the medical record for R68 was reviewed and revealed the following: R68 was initially admitted to the facility on [DATE] and had diagnoses including Liver disease and Spinal stenosis. A review of R68's MDS (minimum data set) with an ARD (assessment reference date) of 9/9/24 revealed R68 needed some assistance from facility staff with most of their activities of daily living. R68's BIMS score (brief interview for mental status) was eight indicating moderately impaired cognition. A Physician's order dated 10/11/24 revealed the following: ALPRAZolam Oral Tablet 0.25 MG (milligrams) (Alprazolam) *Controlled Drug* Give 1 tablet by mouth every 12 hours as needed for for anxiety. Further review of the order revealed no end date and it was ordered for an indefinite period of time. A review of R68's September and October 2024 Medication administration records (MAR) revealed the following dates in which R68 was administered their PRN alprazolam: 9/4, 9/7, 9/11, 9/12, 9/14, 9/16, 10/13, 10/14, 10/15, 10/16, 10/9, 10/20, 10/21. Further review of R68's progress notes and MAR's did not reveal any documentation that R68 was offered non-pharmacological interventions prior to the administration of their PRN alprazolam. On 10/22/24 at approximately 12:45 p.m., during a conversation with the Nurse Manager E (NM E), NM E was queried regarding the administration of PRN alprazolam for R68 and where the non-pharmacological interventions were documented that were attempted prior to administration to ensure the medication as necessary and they reported it was in the progress notes. NM E was queried if it was the standard of practice to ensure that the Nursing staff attempt non-pharmacological interventions prior to administering PRN psychotropic medications and they indicated it was. On 10/23/24 a facility document titled Medications-PRN was reviewed and revealed the following: Policy: PRN medications are administered by staff who are legally authorized to do so through certification or licensure, in accordance with a physician ' s order. Definitions: PRN medication refers to a medication that is taken as needed for a specific situation. It is not provided routinely, and requires assessment for need and effectiveness. Indications for use is the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident ' s condition and therapeutic goals and is consistent with manufacturer ' s recommendations and/or current evidence-based practices or standards. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Documentation will be provided in the resident ' s medical record to show adequate indications for a medication ' s use and the diagnosed condition for which it was prescribed. 2. Orders for medications to be given on an as needed basis shall have clear instructions about how and when to administer them. Examples include, but are not limited to: a. The symptom or condition for which the medication is to be given (i.e., pain, nausea). b. How much of the medication may be given (the dose), and in some instances how much may be given in a set period of time (i.e., one dose five minutes apart for a maximum of three doses). c. When to administer the medication (i.e., every four hours), and in some instances when to take scheduled and PRN medications for a single health problem (i.e., administer routine pain medication as scheduled, and administer prn medication for breakthrough pain at least one hour later).3. When administering a PRN medication: a. Verify physician ' s order for the medication. b. Document the reason voiced by the resident and/or assessment findings that show why the resident needs the medication. Verify the reason is for the prescribed indication for the medication. c. Document the time of administration. d. Document the resident response to the medication. 4. Recurrent use of or repeated requests for PRN medications may indicate the need to reevaluate the situation, including the current medication regimen. Some clinical conditions or situations may require using several analgesics and/or adjuvant medications (e.g., antidepressants or anticonvulsants) together. 5. PRN orders for psychotropic drugs are limited to 14 days. If the prescriber believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident ' s medical record and indicate the duration for the PRN order . Further review of the policy did not indicate that non-pharmacological interventions should be attempted before administering a PRN psychotropic medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41415 Based on observation, interview and record review the facility failed to ensure proper sanitation and disposal of medication tablets for one of two medication carts reviewed. Findings include: On 10/22/24 at approximately 8:35 AM, the medication cart from the 2 [NAME] hallway was reviewed with Licensed Practical Nurse (LPN) N. Upon observation of the first medication drawer, three unidentified pills (peach, white and tan colored round tablets) were laying on the bottom of the drawer. Review of the second drawer revealed seven white and one peach tablet on the bottom of the second drawer. Review of the third drawer revealed one green and one blue round tablet at the bottom of the drawer. LPN N was questioned about the pills found, however was unable to identify the medication and whom it belonged to. During the review of the 2 [NAME] hallway medication cart the Director of Nursing (DON) was asked to observe the pills identified on the bottom of each drawer. The DON stated the medication drawers should be kept clean and the pills should have been discarded per the facility policy. No further explanation or documentation was provided by the end of the survey.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review the facility failed to ensure a Physician ordered laboratory (lab) diagnostic was completed for one resident (R50) of one residents reviewed for diagnostics. Findings include: On 10/21/24 the medical record for R50 was reviewed and revealed the following: R50 was initially admitted to the facility on [DATE] and had diagnoses including Adult failure to thrive and Dementia. A review of R50's MDS (minimum data set) with an ARD (assessment reference date) of 8/19/24 revealed R50 needed assistance from facility staff with their activities of daily living R50's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A Physicians order dated 9/22/24 revealed the following: CBC (complete blood count) , BMP (basic metabolic panel), AND Troponin. Further review of the medical record did not reveal any results form the labs that were ordered on 9/22/24. On 10/22/24 at approximately 12:45 p.m., Nurse Manager E (NM E) was queried regarding the labs results from 9/22/24 and reported that they never got done and there was a miscommunication and the lab was never made aware of the order. NM E reported they had to reorder the labs and would get the completed. On 10/23/24 a facility document titled Laboratory and Diagnostic Guidelines was reviewed and revealed the following: Policy: This guideline is set up to track the timely completion, reporting and monitoring of laboratory and diagnostic tests, results, and notifications which are used to monitor resident status and/or therapeutic medication levels. Policy Explanation and Compliance Guidelines: 1. The facility may consider tracking laboratory (lab) and diagnostic test through various sources. The system is based on the lab provider and facility efficiency. a. Tracking log b. Electronic portal c. Calendar d. Other 2. Routine laboratory or diagnostic test may be placed on a calendar or schedule, or other mechanism. The mechanism should allow for ease of the facility staff to recognize upcoming (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lab and diagnostic tests. 3. Lab and diagnostic test ordered for future dates should also be placed in the same system, again to allow for ease of the facility staff to recognize. 4. Each Lab or entity will have its own process for requisitions. 5. When a new order for labs/diagnostic test is received the nurse should review previous orders for like test to determine if there is conflict, overlap, or rescheduling required. 6. Unless specifically ordered by the physician, routine orders that would fall on a Saturday, Sunday, or holiday may be drawn on the following business or lab day. 7. STAT labs may be obtained per physician order 7 days per week. 8. Orders which require more than one sample, for example stools for occult blood should be placed on a separate line on the log/calendar or per laboratory requirements. 9. The physician should be notified of all refused lab/diagnostic test orders and reason why. 10. The physician should be notified if the lab/diagnostic test is unable to be completed, reason why, and request for new orders. 11. The physician should be notified of all lab/diagnostic test results based on the below parameters. a. Critical lab results or urgent diagnostic should be called to the physician upon receipt. o If at any time the resident is symptomatic or if in the clinician ' s expert opinion the resident needs evaluation and there has been no response from a physician, the Medical Director will be notified. b. Non-critical or non-urgent test results that are abnormal should have physician notification within 24 hours unless the physician has provided specific notification parameters. c. Normal lab/diagnostic results may be faxed to the physician to be reviewed during normal physician hours, unless the physician has ordered immediate reporting of the result. 12. All notifications, attempts at notifications, and response should be noted in the resident ' s medical record. 13. Results should also be reported to the resident and/or responsible party, including any new orders

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 41415 Based on interview and record review the facility failed to ensure the assigned medical director was aware of their job description and fulfilled their responsibility for the coordination of respiratory care for residents that required mechanical ventilation, this had the ability to affect 66 of 66 residents that resided in the facility at the time of the survey. Findings include: During the course of the survey, a systemic failure regarding the Pulmonologist services was identified in the facility that affect all residents that required mechanical ventilation. Due to the severity of the concern, an interview was conducted with the facility's Medical Director. On 10/24/24 at 9:21 AM, the Medical Director (MD) L was interviewed via telephone and asked their involvement in the respiratory care for the facility's ventilator residents. MD L stated they had nothing to do with the respiratory care for the ventilator residents. MD L stated the facility has a Pulmonologist to take care of the respiratory care, however, knew the facility was having a lot of problems with the current Pulmonologist. MD L denied ensuring collaboration of respiratory care was being provided to the mechanical ventilator residents and stated in part . I don't do anything with them, my role is not to run different parties . At that time MD L was made aware that they are indeed listed on the facility's documentation as the Medical Director which would require them to ensure coordination of care amongst all parties in the facility. MD L responded and stated that was not their understanding when they took over the role. Their understanding was that they were assigned to a set of residents and that it was their responsibility to take care of the residents assigned to them. MD L stated there are . a lot of issues that I bring to the Administration staff and it's never fixed . MD L stated if the medical director is responsible for the whole facility then they resign. MD L stated they were calling their employer because that was not the job they signed up for. On 10/24/24 at 11:31 AM and 1:43 PM, the Administrator and Vent Unit Administrator A was interviewed and asked to provide the contract signed by MD L informing them of their job duties and responsibilities. The Administrator and Vent Unit Administrator was informed of the concern regarding the interview conducted with MD L. No explanation was provided. MD L contract and/or additional documentation was not provided by the end of the survey. 38271 On 10/24/24 at approximately 8:42 a.m., Nurse Practitioner U (NP U) was queried if they were the attending NP for any residents in the facility and they indicated that they were. CP U was queried if they oversaw any of the ventilator or tracheostomy (trach) orders for the respiratory/ventilator residents and they indicated they did not. NP U was queried if they knew what Physician over saw the respiratory orders and evaluated the resident ventilator settings that were on ventilators and they reported they did not know. 47283 (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with Nurse Practitioner (NP) T was completed on 10/24/24. During the interview they were queried if they were overseeing the care for ventilator dependent residents and they reported that they were only overseeing residents who were assigned to the medical director. They were queried about the ventilator settings and coordination of care with the pulmonologist for ventilator dependent residents. NP T reported that they did not handle that and they were only coordinating the care with the attending physician who was also the Medical Director.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48680 Based off observations, interviews, and record review the facility failed to provide accurate medical record documentation for services provided for one(R49) resident of four residents reviewed for medical records. Findings include: On 10/21/24 at 10:00AM, R49 was observed in bed with tube feeding running. There were no splints or other adaptive devices present on R49. On 10/21/24 at 1:08 PM, R49's legal guardian(LG) was interviewed regarding care rendered to R49. The LG stated they did have a few concerns. LG stated that R49 was supposed to be on restorative services and that they were afraid that R49 was not getting the services because their hands were becoming more contracted due to it not being enough staff to apply their splints. The LG continued to explain that R49 did not get out of bed on a regular basis because they had a pressure injury on their coccyx and would like to see the Resident up more to promote wound healing. On 10/22/24 at 10:55AM, an interview with the Therapy Manager was conducted and he was asked if R49 was on their case load. The Therapy manager explained the that the Resident was not on case load and they only did the initial screening of the Resident and gave them (the screens) to nursing with recommendations. The Therapy manager was then asked if R49 required bilateral splints for their contractures. The Therapy manager confirmed the resident should have splints and would confer with nursing. On 10/22/24 at 10:57 AM, the Restorative Nurse was interviewed and asked if R49 was on their case load and did they require splints. The Restorative Nurse replied that R49 was on case load and that they did require splints and that should be placed on during the day with periods of rest at night, R49 also had elbow protectors that should be placed on as well. The restorative nurse was informed that R49 did not have on any of the items on and the Restorative nurse stated that they were short a restorative aid but the floor staff should have still completed it. A review of the record revealed that on 10/21/24 that the splint task was signed out and marked tolerated well although the resident did not have the splints on as ordered. On 10/22/24 at 11:20 AM, an interview with the Director of Nursing (DON) was conducted and she was made aware of how R49 presented with no splints but it was documented at 1:34 PM that R49 tolerated well. The DON replied that she did not know the certified nursing assistant would chart that if it did not happen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41415 Based on observation, interview and record review the facility failed to ensure consistent standards of practice for Infection Control were implemented by all staff and ensure the implementation of an effective infection control surveillance program, this had the ability to affect all 66 of 66 residents that reside in the facility at the time of the survey. Findings include: On 10/21/24 at 9:05 AM, the Social Service (SS) personnel B was observed walking into the room of a resident with a signage on the door for Enhanced Barrier Precautions which required everyone who entered and exited to complete hand hygiene. SS B did not complete hand hygiene upon entering. Once inside, SS B conversed with the resident and then was seen exiting the room and heading into another residents room. SS B did not complete hand hygiene prior to exiting the room. SS B was interviewed and asked about the signage on the door and asked why they did not complete hand hygiene before entering and exiting the room. SS B replied they were not providing care to the resident. Additional observations of a Respiratory Therapist was made of them donning on a gown and only tying it at the waist side. The neck and shoulder area of the gown was observed dropping down continuously while the RT was providing tracheostomy care. Another observation was made of a housekeeper entering the room of a resident with an EBP signage on their door, grabbing their breakfast tray and exiting the room. The housekeeper failed to perform hand hygiene upon entering and exiting the room. Infection Surveillance Program Review of the facility's Infection Surveillance Program revealed the following for 2024: September- No monthly analysis or line listing completed. August- No monthly analysis or line listing completed. July- No line listing completed. June- No line listing completed. March- No mapping of infections completed. February- No line listing or mapping completed. January- No documentation maintained for this month. On 10/23/24 at 1:56 PM, the Infection Control Nurse (ICN) O (who also served as the facility's Infection Preventionist) was interviewed and asked about the identified missing components of the Infection Surveillance for the facility from January to current. ICN O explained they had resumed the role of the Infection Control nurse in February 2024 and would look into the missing documentation of the surveillance program. ICN O was informed of the many observations made by the survey team of improper infection control practices by the facility staff and ICN O acknowledged the concern. No further explanation or documentation was provided by the end of the survey. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility policy titled Infection Prevention and Control Program revised 12/27/23, documented in part . The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious disease . A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other individuals . The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any other corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment Performance Improvement .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 41415 Based on interview and record reviews the facility failed to implement an effective antibiotic stewardship program for three R's 46, 3, 223 of three sampled residents reviewed. This deficient practice had the ability to affect multiple residents that resided in the facility who was prescribed an antibiotic. Findings include: Review of the Center for Disease Control's (CDC) The Core Elements of Antibiotic Stewardship for Nursing Homes, dated 2015: .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics when followed over a year . studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic- resistant organisms .Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections .Identify clinical situations which may be driving inappropriate courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use . Review of the March, June & July 2024 infection surveillance logs revealed the following: March- R223 was documented to have a Urinary Tract Infection (UTI) no documentation was noted whether the infection met the McGeer's criteria (the standard utilized to determine the appropriate use of antibiotics to avoid unnecessary use), no signs/symptoms noted, and no documentation of the antibiotic prescribed. Review of the Medication Administration Record (MAR) documented Ceftriaxone intravenous solution as the antibiotic prescribed. June- R3 was documented to have a UTI that did not meet McGeer's criteria. Cefdinir was the antibiotic noted. July- R46 was documented to have a UTI that did not meet McGeer's criteria. Doxycycline was the antibiotic noted. Review of the medical records for R's 223, 3 and 46 revealed no documentation that either antibiotic was reviewed for appropriateness. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 1:56 PM, the Infection Control Nurse (ICN) O (who also served as the facility's Infection Preventionist) was interviewed and asked about the oversight of the facility's Antibiotic Stewardship Program and the review of antibiotic appropriateness for R's 223, 3 and 46. ICN O stated they would look into it and follow back up. At 3:43 PM, ICN O returned and stated they were unable to provide any further documentation. No further information or documentation was provided by the end of the survey.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation and interview, the facility failed to effectively maintain a backup for the facility's resident call system during a partial power outage (for approximately 12 hours) affecting all residents (R26, R33 and R44) on the one west hall resulting in the potential for a delayed emergency response and/or negative resident outcome. Findings include: R26 Record review revealed R26 was a long-term resident of the facility. R26 was residing in the one [NAME] Hall. R26 was admitted to the facility on [DATE]. R26's admitting diagnoses included heart failure with presence of pacemaker, atrial fibrillation, chronic pain, and chronic kidney disease. Based on the Minimum Data Set (MDS) assessment dated [DATE], R26 had a Brief Interview for Mental Status (BIMS) score of , d+[DATE], indicative on intact cognition. R26 needed extensive staff assistance with their mobility in bed and transfers. During an initial interview with R26 completed on [DATE] at approximately 9:10 AM. During the interview R26 reported that the facility had some generator issue on [DATE], in the afternoon, after 5 PM. R26 added that the facility lost part of the power and their call light system on the unit were not working. When queried further R26 reported that it happened approximately around 5 PM on [DATE] and they did not get the power back until [DATE] morning. They added that red plugs/outlets (emergency outlets) on their side of the room did not work. The showed the remote pacemaker monitor (that was plugged to the outlet behind the bed) and stated that it was not working and they were concerned because the call light system was also not working. When queried if facility has provided a backup system/bell to alert the staff, R26 reported that the facility did not provide any back up system to alert staff and that was why they were concerned. When queried if staff members were aware of the concern, R26 reported that staff were aware. R26 reported that they had called the facility Receptionist V on [DATE] and spoke with them and they had requested to speak with the facility administrator and the receptionist had notified R26 that administration had left for the day. When queried how they had alerted the staff members, R26 reported that they had to yell out to alert staff. R26 reported that they had called the ombudsman and had left a message for them. During a follow up interview completed on [DATE] at approximately 4:15 PM, R26 confirmed the above details that they had provided to the surveyor on [DATE]. R33 Record review revealed R33 was a long-term resident originally admitted to the facility on [DATE]. R33's admitting diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and panic disorder. Based on the MDS assessment dated [DATE], R33 had a BIMS score of ,d+[DATE], indicative of intact cognition. An interview with R33 was completed on [DATE] at approximately 12:30 PM. During the interview they were queried about the power outage. R33 reported that it happened on [DATE] and the call light system on their unit was not working. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was completed on [DATE] at approximately 4:10 PM. During this interview R33 confirmed that call light system on their unit was not working throughout the night of [DATE] and they were not provided with any back up call system to alert staff when they needed help. R33 also confirmed that the facility staff were aware of the non-working call light. R44 Record review revealed R44 was a long-term resident admitted to the facility on [DATE]. R44's admitting diagnoses included COPD, heart failure, obstructive sleep apnea, and diabetes. Based on the MDS assessment dated [DATE], R44 had a BIMS score of ,d+[DATE], indicative of intact cognition. An initial observation was completed on [DATE] at approximately 10:30 AM. R44 was observed in their bed. R44 was receiving oxygen through a nasal cannula. They had confirmed that the facility had power outage on [DATE] and the call lights were not working during this time. A follow-up interview was completed on [DATE] at approximately 10 AM. They were sitting on the edge of the bed and receiving oxygen. They were queried about the power outage on [DATE]. R44 reported that on [DATE] afternoon (around 4:30 PM) the facility had a partial power outage and the red outlets behind their bed were not working and their call light were not working through the whole night until the next morning, approximately 8 AM. They added that the staff were aware that the call light were not working and they did not have alternate means to alert the staff of help they needed. When queried further R44 added that their oxygen concentrator and Continuous Positive Airway Pressure (CPAP) machine were not working that night and they were using a portable oxygen tank. R44 added that they had to use their cell phone to call the facility to alert staff when they needed a new oxygen tank. R44 showed the phone to the surveyor and there were calls made to the facility on [DATE] at 2:40 AM and 5:57 AM. An interview was completed with the receptionist V on [DATE] at approximately 4:25 PM. Receptionist V confirmed that they had a power outage on [DATE]. They were queried if they had received any calls from the residents that evening with any concerns. They reported that they received calls from different residents, including R26 and they reported that their call lights were not working. They added that they had notified maintenance. An interview with the ombudsman W was completed on [DATE] at approximately 11 AM. During the interview Ombudsman W confirmed that they had received a call from resident(s) about the power outage on [DATE] and call lights were not working. An interview with facility's Assistant Administrator (AA) A was completed on [DATE] at approximately 10:15 AM. They reported that they were not in the facility on the day of the incident, but they were aware of the situation as they were receiving the group messages and they were able to answer questions about the outage. AA A reported that they had a faculty generator transfer switch that caused the outage on [DATE]. They were queried if they were aware of call lights that were not working on one west unit and they reported that they were not aware of the issue. They added that the facility had two generators and the call light system was connected to the smaller generator and they did not have any trouble with that unit. AA A was notified of the call light concerns from [DATE] reported by multiple residents in the one [NAME] hallway. They reported that they would check with the facility vendor and provide additional documentation to show the facility's call light system was connected to the smaller generator. Later they reported that they had an appointment with the vendor and would provide additional documentation. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further explanation or additional information was provided prior to the survey exit. An interview with the Director of Nursing (DON) was completed on [DATE] at approximately 3:45 PM. The DON reported that they were at the facility till 10 PM on the day of the power outage and they were unaware that the call lights on the one west unit were not functioning. They added that they would have provided bells or an alternate system for the residents if they were made aware of the situation. The DON was notified of the concern from multiple residents from the one west hall and they reported that they understood the concern. A facility provided document titled Call Lights: Accessibility and Timely Response with a revision date [DATE] read in part, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: 1. Staff are educated in the proper use of the resident call system, including how the system works and ensuring resident access to the call light. 2. Residents are educated on how to call for help by using the resident call system. 3. Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. 4. Special accommodations will be identified on the resident's person-centered care plan, and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) 5. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and provides immediate or alternative solutions until the problem can be remedied . (Examples include replace call light, provide a bell or whistle, increase frequency of rounding, etc.) .