STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235311	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamo Nursing Home Inc	8290 W C Ave Kalamazoo, MI 49009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation and interview, the facility failed to maintain a dignified existence for 3 residents (Resident #81, Resident #9, and Resident #10) of 18 residents reviewed for dignity, resulting in long call light wait times, residents being left wet and soiled, and feelings of frustration, anxiety, and embarrassment. Findings include: Resident #81 Review of an Admission Record revealed Resident #81, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: repeated falls, weakness, and age-related physical debility. Review of a Minimum Data Set (MDS) assessment for Resident #81, with a reference date of 3/18/24, revealed a Brief Interview for Mental Status (BIMS) which indicated Resident #81 was cognitively intact. Section D of the MDS revealed Resident #81 experienced feeling down, depressed, or hopeless during 2-6 days of the 14-day assessment period. Section E of the MDS revealed Resident #81 did not reject care. Review of a Care Plan for Resident #81 with a reference date of 3/7/24 revealed a focus/goal/interventions: Focus: Resident has an ADL self-care performance deficit .related to repeated falls, Goal: Resident will maintain current function .Interventions: assist resident to meet toileting needs . In an interview on 4/30/24 at 1:39pm, Resident #81 reported she was unable to safely take herself to the bathroom and always used to call light when she needed assistance. Resident #81 reported she had waited up to 2 hours for a staff member to respond after her call light had been activated. Resident #81 reported at times her significant other would come and take her to bathroom because she'd waited so long, but that really wasn't safe for either of them do to that. In an interview on 4/30/24 at 4:20pm, Certified Nursing Assistant (CNA) P, a CNA on Resident #81's hall, reported it had becoming increasingly difficult to answer call lights in a timely manner and she was aware that residents were experiencing long wait times and several residents, including Resident #81, had expressed frustration with the slow response. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/2/24 at 11:31am, Certified Nursing Assistant (CNA) J reported she was aware residents had experienced long call light wait times, greater than 30 minutes in recent months. CNA J reported they (the residents) are paying for good care, and they're not getting it. In an interview on 5/2/24 at 11:21am, Resident #81 reported staff members frequently told her there was not enough staff to allow for call lights to responded to in a timely manner. Resident #81 reported felt frustrated by the long waits to use the bathroom and also became anxious while waiting because she was concerned she'd have an episode of incontinence. 41027 Resident #9 Review of an Admission Record revealed Resident #9 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety, depression, and prostate gland enlargement that can cause urination difficulty. Review of a Minimum Data Set (MDS) assessment for Resident #9, with a reference date of 3/15/24 revealed a Brief Interview for Mental Status (BIMS) which indicated Resident #9 was cognitively impaired. In an interview on 04/30/24 at 10:10 AM, Resident #9 reported that his call light had been on for over 30 minutes, and at times he had waited up to 6 hours to have his brief changed, especially if it was between shifts or around meal times, and stated, .I hear them in the hall .they say let that one go, he wants help all the time . Resident #9 reported that he would rather be changed in bed, because it hurts to stand and he gets left on the commode for hours. Resident #9 reported that his brief was soaking wet and that the last time he had been changed was at 5:00 AM (5 hours ago) that day. In an interview on 05/01/24 at 08:04 AM, Resident #9 reported that he had a wet brief, and had not been changed or cleaned up since 3:00 AM that day. Resident #9 reported that the CNA's (Certified Nursing Assistant) were busy getting people up now, and then they have to feed everyone, and then they will have to pick up all the trays, and then they will get busy changing people. Resident #9 reported that the CNA's have told him those things, and stated, .they will get mad at me if I bother them while they are busy .they will do it when they are ready .if I put my call light on now I will wait and wait and they will say they don't have time .I don't want them mad at me . Resident #9 pressed his call light at 8:12 AM. During subsequent observations on 05/01/24 from 8:12 AM-8:22 AM there were 2 CNA's in the hall passing trays and 2 Activity staff in the hallway passing out calendars. At 8:22 AM Registered Nurse (RN) KK walked down the hall and stated, I miss the old call lights, and then informed CNA W that Resident #9's call light was on. During an observation on 05/01/24 at 8:23 AM, CNA W entered Resident #9's room, and the resident said I need to be changed, but I don't want to stand up. CNA W asked Resident #9 which brief he wanted, and then turned to this surveyor and said, He gets really picky about his brief. Resident #9 heard the comment, but did not say anything. CNA W donned gloves, and changed the resident's brief that was heavily saturated with urine. Afterwards, Resident #9 stated, .I really appreciate you doing this ., and CNA W replied, .yeah, usually I don't have time to do it . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/24 at 8:19 AM, Activity Aide (AA) ZZ reported that she was expected to help answer call lights, but that she didn't know if a resident's call light was on until she went into their room. AA ZZ reported that she did not carry a call light cell phone, so she did not get the alerts. Resident #10 Review of an Admission Record revealed Resident #10 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: depression, PTSD (post traumatic stress disorder) cerebral palsy (birth defect that causes disorder of movement, muscle tone and posture) and an overactive bladder. Review of a Minimum Data Set (MDS) assessment for Resident #10, with a reference date of 3/1/24 revealed a Brief Interview for Mental Status (BIMS) which indicated Resident #10 was cognitively intact. Review of Resident #10's Care Plan revealed, Focus: .has frequent bladder incontinence at night only and I am usually continent of bowel .Wears briefs at night .Date Initiated: 3/19/24 . In an interview on 04/30/24 at 01:34 PM, Resident #10 reported that staff frequently complained about being short handed and that it is the worst during the night hours. Resident #10 reported that at times she presses her call light to have her incontinence brief changed, and that at times she has waited over 2 hours and stated, .I get sore .it burns .it soaks through my sheets .it doesn't make me feel very good . Resident #10 reported that half of the time the CNA's don't even know that her light was on when they come into the room, because they weren't carrying a call light phone with them. Resident #10 reported she waited from 5:20 AM to 8:00 AM that day for her call light to get answered, and the whole time she laid in a wet brief.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 Based on interview, and record review, the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) for Medicare Part A services in 3 of 3 residents (Resident #89, #90, & #91) reviewed for timely provision of notifications, resulting in the potential for the resident or resident representative to be unaware of changes in regard to financial liability, frustration, and a delay in the ability to file an appeal. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) page titled Beneficiary Notices Initiative (BNI) revealed .Both Medicare beneficiaries and providers have certain rights and protections related to financial liability and appeals under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers . Retrieved from https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative Review of the Centers for Medicare and Medicaid Services (CMS) page titled FFS & MA NOMNC/DENC revealed .HHAs (Home Health Agencies), SNFs (Skilled Nursing Facilities), Hospices, and CORFs (Comprehensive Outpatient Rehabilitation Facilities) are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when their Medicare covered service(s) are ending. The NOMNC informs beneficiaries on how to request an expedited determination from their Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and gives beneficiaries the opportunity to request an expedited determination from a BFCC-QIO . Retrieved from https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-nomnc-denc Review of the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, no date, revealed .Medicare provider or health plan (Medicare Advantage plans and cost plans, collectively referred to as plans) must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily . Resident #89 Review of an Admission Record revealed Resident #89 was a female, who originally admitted to the facility on [DATE] with Medicare Part A as her primary payer, which indicated Medicare Part A paid for services provided to the resident beginning on that date. Noted Resident #89 discharged from the facility to home on 3/21/24. Review of Resident #89's MDS records revealed a Discharge Assessment was completed with a reference date of 3/21/24. Review of Section A2400 revealed Resident #89 had a Medicare covered stay, with a start date of 3/1/24 and an end date of 3/21/24. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SNF Beneficiary Notification Review form for Resident #89, completed by facility staff, revealed .Last covered day of Part A Service .3-20-24 .Was a NOMNC, Form CMS-10123 provided to the resident? .No .The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA) . Review of the Discharge Instructions for Resident #89, dated 3/20/24, revealed .Date of Discharge . 03/21/2024 .Reason for Discharge .Discharge goals met .Completion of therapy . No documentation was provided by the facility prior to survey exit to indicate that the beneficiary initiated the discharge. Resident #90 Review of an Admission Record revealed Resident #90 was a female, who originally admitted to the facility on [DATE] with Medicare Part A as her primary payer, which indicated Medicare Part A paid for services provided to the resident beginning on that date. Noted Resident #90 discharged from the facility to home on 3/7/24. Review of Resident #90's MDS records revealed a Discharge Assessment was completed with a reference date of 3/7/24. Review of Section A2400 revealed Resident #90 had a Medicare covered stay, with a start date of 2/23/24 and an end date of 3/7/24. Review of the SNF Beneficiary Notification Review form for Resident #90, completed by facility staff, revealed .Last covered day of Part A Service .3-6-24 .Was a NOMNC, Form CMS-10123 provided to the resident? .No .The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA) . Review of the Discharge Instructions for Resident #90, dated 3/6/24, revealed .Date of discharge .3/7/24 . Reason for discharge .Discharge goals met . No documentation was provided by the facility prior to survey exit to indicate that the beneficiary initiated the discharge. Resident #91 Review of an Admission Record revealed Resident #91 was a female, who originally admitted to the facility on [DATE] with Medicare Part A as her primary payer, which indicated Medicare Part A paid for services provided to the resident beginning on that date. Noted Resident #91 discharged from the facility to home on 3/8/24. Review of Resident #91's MDS records revealed a Discharge Assessment was completed with a reference date of 3/8/24. Review of Section A2400 revealed Resident #91 had a Medicare covered stay, with a start date of 2/3/24 and an end date of 3/8/24. Review of the SNF Beneficiary Notification Review form for Resident #91, completed by facility staff, revealed .Last covered day of Part A Service .3-7-24 .Was a NOMNC, Form CMS-10123 provided to the resident? .No .The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, & discharged in the same day; Resident discharged AMA) . (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Discharge Instructions for Resident #91, dated 3/6/24, revealed .Date of discharge .3/8/24 . Reason for discharge .Discharge goals met .Completion of therapy . No documentation was provided by the facility prior to survey exit to indicate that the beneficiary initiated the discharge. In an interview on 5/2/24 at 1:44 PM, Rehab Director NN reported Resident #89, #90, and #91 met their rehabilitation goals prior to discharge from the facility. In an interview on 5/2/24 at 2:43 PM, Business Office Manager (BOM) H reported NOMNC forms were not provided to Resident #89, #90, and #91. BOM H reported all three of the residents reviewed had met their goals and were ready for discharge home. BOM H reported the facility only issues NOMNC forms to residents who discharge from therapy services, but remain in the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans in 2 of 18 residents (Resident #11 & #13) reviewed for comprehensive care plans, resulting in the potential for falls/injury for Resident #11 and a lack of resident-centered interventions related to a history of trauma for Resident #13. Findings include: Resident #11 Review of an Admission Record revealed Resident #11 was a female, with pertinent diagnoses which included Alzheimer's disease, depression, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #11, with a reference date of 3/29/24, revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated severe cognitive impairment. Review of a current Care Plan for Resident #11 revealed the focus .I require Routine Fall Precautions per Fall Assessment . revised 2/20/24, with interventions which included .Gripper socks on when in bed . revised 2/5/24, and .Bed: [NAME] bed, low in use with fall mat . revised 4/4/24. Review of a current Care Plan for Resident #11 revealed the focus .I have a Self Care and Mobility deficit with weakness, confusion and H/O (history of) L (left) hip fx (fracture) .I have slowly recovered my ambulation skills with device and assist. I have high confusion with need for existing care assist with continued LTC (Long-Term Care) . revised 2/7/24, with interventions which included .BED MOBILITY: Needs ext-dep (extensive to dependent) assist, bed low in use with fall mat . revised 4/11/24. In an observation on 4/30/24 at 4:27 PM, Resident #11 was in bed in her room. Noted Resident #11 was wearing regular socks (not gripper socks). Observed a blue padded floor mat folded and leaning against Resident #11's tray table, on the opposite side of the room (not in place along Resident #11's bed). In an interview on 5/2/24 at 9:22 AM, Certified Nursing Assistant (CNA) N reported Resident #11 is a fall risk. CNA N reported when Resident #11 is in bed, the bed should be in the lowest position with a padded fall mat in place along the side. In an observation on 5/2/24 at 1:34 PM, Resident #11 was in bed in her room. Observed a blue padded floor mat folded and positioned behind the head of the bed (not in place along Resident #11's bed). Noted Resident #11 appeared restless, and was attempting to roll toward the edge of the bed. 46999 Resident #13 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #13, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression, anxiety disorder, bipolar disorder (disorder causing extreme mood swings). Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 3/26/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #13 was cognitively intact. Section D of the MDS revealed: Resident #13 had experienced feeling down, depressed, or hopeless during half or more of the 14-day assessment period and had trouble sleeping nearly every day. Review of a Kardex (brief overview of care needs) for Resident #13 revealed in a section titled Behavior/Mood: Resident is specifically anxious at night and being along .remind resident of her safety, check on her if she is awake at night .make sure she knows she is safe during fire drills . Review of a Social Service Initial Evaluation for Resident #13 with a reference date of 3/18/24 revealed under section IV, Trauma Informed Care: Resident was recently in a fire where she was residing .had to pulled out by firefighters and was hurt physically .resident gets tearful talking about it. Further review revealed Resident #13 reported she had trouble sleeping, fear of going to sleep, sadness, and anxiety when she relived the experiences she had during the fire. Review of a Psychiatric Evaluation and Consultation report with a reference date of 3/19/24 revealed in a section titled Current Assessment: Resident does report feeling sad, down .I wish I could stop crying . Resident does admit to nightmares, flashbacks of the fire .Resident lived in a hotel prior to coming to the facility and her hotel caught fire. Review of a section titled Plan revealed: To ensure the resident Is on the lowest dose of psychotropic medication, nursing staff will .utilize 1:1 time with the resident, redirection, assisting the resident to a less stimulating environment when behaviors occur . These interventions were not present in the plan of care. Review of a Psychiatric Evaluation and Consultation report with a reference date of 4/8/24 revealed in a section titled Current Assessment: Staff report that (Resident #13) is tearful .more agitated/anxious daily . continues to stay in her bed, not often out of her room to socialize .she (Resident #13) does admit to hallucinations, I smell smoke, and see smoke. Reveal of a section titled Plan revealed: Care partners will . continue to provide nonpharmacological interventions to resident as needed . Review of a Care Plan for Resident #13 with a reference date of 3/15/24 revealed no focus/goal/interventions related to the recent trauma Resident #13 experienced during a fire. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/1/24 at 2:22pm, Resident #13 reported she continued to recover from the trauma of being in a life-threatening situation during a recent fire. Resident #13 reported shortly after her admission to the facility, she was scared and became very anxious when a fire drill was implemented. Resident #13 stated I went into a panic and was thinking about how I could get out of the building because I thought there was a fire. Resident #13 reported she preferred to be out of the building during fire drills, but at a minimum needed to be aware of the drill prior to it happening. Resident #13 reported she also wanted staff to know that she felt anxious when her door was closed and that she was worried that she smelled campfire smoke from a nearby campground during the upcoming summer, she may become more anxious and need additional reassurance. Resident #13 also wanted those that provided her care to know that she benefited emotionally from talking about her recent trauma. Resident #13 reported she felt these needs should be shared in her plan of care. In an interview on 05/02/24 at 10:11am, Social Services Director (SS) OO reported it was important to put interventions into place and educate staff about residents' trauma triggers to avoid additional trauma. SS OO reported Resident #13 had experienced a fire in her home prior to coming to the facility and had ongoing symptoms of trauma as a result. SS OO reported she had no educated all the staff that cared for Resident #13 about the resident's history of trauma, her triggers, or care interventions. SS OO reported Resident #13 frequently thought she smelled smoke, had trouble sleeping, and needed ongoing reassurance that she was safe. SS OO confirmed that a care plan should have been developed to address Resident #13's psychosocial needs related to her history of trauma. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.18.11, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, dated October 2023, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences.A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings .The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures. Nurses revise a plan when a patient's status changes . The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to Intake #MI00142619. Based on observation, interview, and record review, the facility failed to maintain professional standards of care and provide adequate incontinence care in 2 of 3 residents (Resident #9 & #41) reviewed for bowel and bladder incontinence, resulting in an increased risk for UTI (urinary tract infection) and the potential for skin breakdown. Findings include: Resident #9 Review of an Admission Record revealed Resident #9 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: prostate gland enlargement that can cause urination difficulty. Review of a Minimum Data Set (MDS) assessment for Resident #9, with a reference date of 3/15/24 revealed a Brief Interview for Mental Status (BIMS) which indicated Resident #9 was cognitively impaired. Review of Resident #9's ADL (activities of daily living) Care Plan revealed, .self-care performance deficit r/t (related to) mobility deficit and continued coordination/motor panning challenges .Interventions: .Toilet Use: The resident requires ext-dep (extensive to dependent care) by 1 staff for toileting. Wears briefs. Date Initiated: 3/29/24 . Review of Resident #9's Incontinence Care Plan revealed, .has bladder/bowel incontinence r/t (related to) decreased sensation/control .Goal: Resident will be clean, dry, and odor-free though the review date. Resident will be continent during waking hours . Resident will remain free from skin breakdown due to incontinence and/or incontinence product use .Resident's risk for urinary infections and complications will be minimized .Date Initiated: 3/29/24. Interventions: .uses incontinence management products. Change per protocol, preference and as needed. Clean peri-area with each incontinence episode . Date Initiated: 3/29/24. In an interview on 04/30/24 at 10:10 AM, Resident #9 reported that his call light had been on for over 30 minutes, and at times he had waited up to 6 hours to have his brief changed, that his brief was soaking wet and that the last time he had been changed was at 5:00 AM (5 hours ago) that day. In an interview on 05/01/24 at 08:04 AM, Resident #9 reported that he had a wet brief, and had not been changed or cleaned up since 3:00 AM that day. (continued on next page)

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	235311	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamo Nursing Home Inc	8290 W C Ave Kalamazoo, MI 49009

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/01/24 at 8:23 AM, CNA (Certified Nursing Assistant) W entered Resident #9's room, and the resident said I need to be changed, but I don't want to stand up. CNA W donned gloves, asked Resident #9 to roll to his side, she removed the brief that was heavily saturated with urine on the bottom side, and quickly applied a clean brief, and pulled the resident's pants back up with the same gloves on. CNA W did not wash the resident's buttocks or penis. Resident #9 asked CNA W if she had cleaned his butt and the CNA replied, You didn't have a BM (bowel movement). Resident #9 requested that the CNA wash him. CNA W grabbed a disposable wipe and swiped it over the resident buttocks and then used another wipe and swiped down both sides of the residents groin fold. CNA W did not wash the penis at all. Resident #9 stated, .I really appreciate you doing this ., and CNA W replied, .yeah, usually I don't have time to do it . In an interview on 05/01/24 at 08:36 AM, CNA W reported that she wasn't going to wash Resident #9's peri-area because he did not have a BM, and then when she did wash him, she forgot to clean his penis. Resident #41 Review of an Admission Record revealed Resident #41 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke and paralysis (inability to move body). Review of a Minimum Data Set (MDS) assessment for Resident #41, with a reference date of 3/22/24 revealed a Brief Interview for Mental Status (BIMS) which indicated Resident #41 was cognitively intact. Review of Resident #41's Kardex (direct care guide) revealed, .Bladder/Bowel: Brief use: The resident uses adult disposable briefs. Goal of check/change Q2-3hrs (every 2-3 hours) & PRN (as needed) . In an interview on 05/01/24 at 12:11 PM, Resident #41 reported that he received incontinence care at 11:30 PM the night before and then not again until 6:00 AM today, when the shower aide came to get him for a shower. Resident #41 reported that CNA V came in that morning and told him that she would come change me when she was done with the other residents and stated, .the last time I was changed was 6:30 AM with my shower .they are short staffed .they told me 2 or 3 people called in today . In an interview on 05/01/24 at 01:04 PM, CNA V reported that she would be doing cares on Resident #41 as soon as she can and stated, .there's still a couple people ahead of him . During an observation on 05/01/24 at 01:33 PM, CNA V reported that she had to go retrieve linens from the laundry room for Resident #41. At 1:37 PM CNA V entered Resident #41's room and told him that she was waiting for CNA MM to come from another hall to assist her. At 1:41 PM CNA MM arrived to assist with Resident #41's care. CNA V detached Resident #41's brief and it was noted soaking wet with urine. CNA V wash the front peri-area, but did not touch or clean the penis. The CNA's then turned Resident #41 onto his left side and there was dried BM (bowel movement) noted on Resident #41's buttocks, and a superficial wound noted on the right buttock. CNA V reported that the wound is chronic and fluctuates being open and closed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a interview on 05/01/24 at 01:53 PM, CNA V reported that she did not clean Resident #41's penis, and that she was not sure when gloves needed to be changed during incontinence care. CNA V reported that she usually tried to get to Resident #41 before lunch, but she had to wait for help form another hall. In an interview on 05/02/24 at 09:30 AM, Resident #41 reported that he does not refuse incontinence care, and knows that staff should come in every 2 hours and stated, .last night no one came until 5:00 AM . In an interview on 05/02/24 at 01:59 PM, CNA BBB reported that Resident #41 had never refused incontinence care for her.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on interview, and record review the facility failed to identify traumatization triggers and implement interventions to mitigate these triggers for 1 (Resident #13) of 18 residents reviewed for trauma informed care, resulting in Resident #13, who had recently survived a life-threatening fire, experiencing fear and anxiety during a fire drill, and a potential for unmet psychosocial needs. Findings include: Review of an Admission Record revealed Resident #13, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression, anxiety disorder, bipolar disorder (disorder causing extreme mood swings). Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 3/26/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #13 was cognitively intact. Section D of the MDS revealed: Resident #13 had experienced feeling down, depressed, or hopeless during half or more of the 14-day assessment period and had trouble sleeping nearly every day. Review of a Care Plan for Resident #13 with a reference date of 3/15/24 revealed no focus/goal/interventions related to the recent trauma Resident #13 she experienced during a fire in her residence. Review of a Social Service Initial Evaluation for Resident #13 with a reference date of 3/18/24 revealed under section IV, Trauma Informed Care: Resident was recently in a fire where she was residing .had to be pulled out by firefighters and was hurt physically .resident gets tearful talking about it. Further review revealed Resident #13 reported she had trouble sleeping, fear of going to sleep, sadness, and anxiety when she relived the experiences she had during the fire. Review of a Psychiatric Evaluation and Consultation report with a reference date of 3/19/24 revealed in a section titled Current Assessment: Resident does report feeling sad, down .I wish I could stop crying . Resident does admit to nightmares, flashbacks of the fire .Resident lived in a hotel prior to coming to the facility and her hotel caught fire. Review of a Psychiatric Evaluation and Consultation report with a reference date of 4/8/24 revealed in a section titled Current Assessment: Staff report that (Resident #13) is tearful .more agitated/anxious daily . continues to stay in her bed, not often out of her room to socialize .she (Resident #13) does admit to hallucinations, I smell smoke, and see smoke. Review of a Fire Drill and Emergency Plan Training record revealed the facility completed a fire drill on 3/29/24 at 10:45pm. The overhead alarms were activated at 10:45pm and ended at 11:05pm. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/1/24 at 2:41pm, Maintenance Director (MD) GG he planned the monthly fire drills that were conducted throughout the facility. During the drills the overhead alarms sounded, a flashing red light was placed somewhere in the building, staff members were expected to race to the fire carrying fire extinguishers, the magnetic doors in the halls closed immediately, staff closed resident doors as quickly as possible and maintenance staff asked staff members Do you smell smoke?! and similar questions to simulate a real emergency. When further queried, MD GG reported he was not aware of any residents who could potentially be re-traumatized by fire drill activities. In an interview on 4/30/24 at 11:02am, Resident #13 reported she was admitted to the facility after she fell and was injured while trying to escape a fire in her residence. Resident reported she was pulled from the fire by a firefighter. Resident #13 reported after her experience during the fire, she was afraid to try to walk and was mentally unable to do so for several weeks. In an interview on 5/1/24 at 2:22pm, Resident #13 reported she continued to experience symptoms from the trauma of being in a life-threatening situation during a recent fire. Resident #13 reported the fire happened in the middle of the night and she awoke, gasping for air in thick smoke, then fell and could not get up as she tried to exit the building. Resident #13 reported she felt the heat from the fire on her back as she tried to get up, and recalled being struck by small embers as she was pulled from the fire. Resident #13 reported she continued to experience hallucinations of smelling smoke and seeing fire, and continued to constantly question her own safety. Resident #13 reported shortly after her admission to the facility, she was scared and became very anxious when a fire drill was implemented. Resident #13 stated I went into a panic and was thinking about how I could get out of the building because I thought there was a fire. Resident #13 reported she would prefer to be out of the building when possible, during fire drills, and at a minimum needed to be aware of the drill prior to it happening. In an interview on 05/02/24 at 10:11am, Social Services Director (SS) OO reported it was important to put interventions into place and educate staff about residents' trauma triggers to avoid additional trauma. SS OO reported Resident #13 had experienced a fire in her home prior to coming to the facility and had ongoing symptoms of trauma as a result. SS OO reported she had no educated all the staff that cared for Resident #13 about the resident's history of trauma, triggers, and care interventions. SS OO reported Resident #13 frequently thought she smelled smoke, had trouble sleeping, and needed ongoing reassurance that she was safe. When further queried about interventions in place for Resident #13 regarding the facility's monthly fire drills, SS OO reported the facility had not put any interventions in place when Resident #13 experienced a fire drill shortly after her admission and during the fire drill, Resident #13 experienced fear and anxiety. Review of a facility Behavioral Health Services policy with a reference date of 7/11/18 revealed a policy statement: It is the policy of this facility that each resident must receive the necessary behavioral health care . to attain the highest practicable .mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care .a resident .who has a history of trauma .receives appropriate treatment and services .to attain the highest practicable mental and psychosocial well-being.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36221 This citation pertains to Intake # MI00142619. Based on observation, interview, and record review, the facility failed to provide sufficient staff to meet resident needs in 5 of 8 residents (Resident #9, #10, #33, #41, & #55) reviewed for sufficient staffing, resulting in long call light wait times, residents being left wet and/or soiled for extended periods of time, missed showers/baths, late medications, and staff burnout. For additional information see citation F550 and F919. Findings include: Review of the Resident Council meeting minutes, dated 3/1/24, revealed .Residents not receiving showers on their selected day and time. Staff tell residents they are unable to give showers or tub baths due to not enough staff scheduled .Some residents have gone 8 days in a row without a shower .Residents wanting a tub bath are told they cannot get one due to time allowed and not enough staff .Residents who require a 2-person assist are only being assisted with 1 staff person. This happens often on 2nd and 3rd shift including weekends .Residents are fearful that staff will not be able to assist them on weekends when they do not see enough staff in the building on weekends .Residents state they are not given pain medication in a timely manner. Often, they are 1-2 hours late .Residents state that daily medications are not given in a timely manner. Medications are usually 2-4 hours late .Residents state they are not (being) assisted to get up in the morning in a timely manner .Residents often miss morning activities due to being left in bed. Staff tell the residents that they are short-staffed .Long call light waits 2nd and 3rd shift. On weekends residents state they can wait up to an hour before someone assists them . In an interview on 5/1/24 at 3:55 PM, Licensed Practical Nurse (LPN) FF reported staffing is an issue at the facility. LPN FF reported when short-staffed, call lights go unanswered for extended periods of time, sometimes .hours . LPN FF reported management often does not assist when short-staffed, and stated . many days we don't get our lunch breaks .It's a struggle . LPN FF reported sometimes the CNA's are not able to complete scheduled showers due to low staffing, and residents often have to wait long periods of time to be toileted. LPN FF reported when short-staffed it can be difficult to complete two person transfers timely, and stated .They (the residents) have to wait a while . 41027 Resident #9 Review of an Admission Record revealed Resident #9 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety, depression, and prostate gland enlargement that can cause urination difficulty. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/24 at 10:10 AM, Resident #9 reported that his call light had been on for over 30 minutes, and at times he had waited up to 6 hours to have his brief changed, especially if it was between shifts or around meal times, and stated, .I hear them in the hall .they say let that one go, he wants help all the time . Resident #9 reported that he would rather be changed in bed, because it hurts to stand and he gets left on the commode for hours. Resident #9 reported that his brief was soaking wet and that the last time he had been changed was at 5:00 AM (5 hours ago) that day. In an interview on 05/01/24 at 08:04 AM, Resident #9 reported that he had a wet brief, and had not been changed or cleaned up since 3:00 AM that day. Resident #9 reported that the CNA's (Certified Nursing Assistant) were busy getting people up, then they would have to feed everyone, then they have to pick up all the trays, and then they get busy changing people. Resident #9 reported that the CNA's have told him those things, and stated, .they will get mad at me if I bother them while they are busy .they will do it when they are ready .if I put my call light on now I will wait and wait and they will say they don't have time .I don't want them mad at me . Resident #9 pressed his call light at 8:12 AM. During observations on 05/01/24 from 8:12 AM-8:22 AM there were 2 CNA's in the hall passing meal trays and 2 Activity staff in the hallway passing out calendars. At 8:22 AM Registered Nurse (RN) KK walked down the hall and stated, I miss the old call lights, and then informed CNA W that Resident #9's call light was on. During an observation on 05/01/24 at 8:23 AM, CNA W entered Resident #9's room, and the resident said I need to be changed, but I don't want to stand up. CNA W donned gloves, asked Resident #9 to roll to his side, she removed the brief that was heavily saturated with urine on the bottom side, and quickly applied a clean brief, and pulled the resident's pants back up with the same gloves on. Resident #9 stated, .I really appreciate you doing this ., and CNA W replied, .yeah, usually I don't have time to do it . In an interview on 05/01/24 at 08:36 AM, CNA W reported that she doesn't normally get time to care for Resident #9 until mid morning. CNA W reported that she was the only CNA on the unit (over 20 residents) for an hour, until CNA V came to help and stated, .there was no CNA on third shift when I got here .I did not get any report . In an interview on 05/01/24 at 08:43 AM, RN KK reported that she was behind on medication pass because she had been helping the CNA's and stated, .2 CNA's is not enough on basic hall, they can't do it on their own .I help with call lights, transfers .we have lots of fall risks, behaviors and 2 person assists . RN KK reported that the shift started short handed that day and stated, .the CNA on third shift left at 4:00 AM and there was only 1 nurse for this unit and north unit .and there was only 1 CNA here for the first hour of first shift because there was a call in . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/02/24 at 09:43 AM, Employee Scheduler (ES) G regarding why there was no CNA on basic hall on 5/1/24 when first shift staff arrived. ES G reported that CNA CCC was scheduled until 4:00 AM on 5/1/24 and CNA S was scheduled to come in early at 4:00 AM to cover the shift. ES G reported that the third shift staff (1 nurse and 1 CNA) on basic hall are expected to help with morning cares and getting residents out of bed. ES G reported that on first shift 5/1/24 there was also a call in for basic hall, and one on rehab hall, therefore CNA V was pulled from south hall to cover basic, and CNA MM was pulled from her normal job of assisting with meals, weights, and ambulation programs to help on rehab and south halls. ES G reported that CNA V should have been pulled as soon as she arrived at 6:00 AM. ES G reported that CNA MM normally gets pulled a couple times a week to cover call ins and had been pulled the past 2 days. ES G reported that when there was a float CNA scheduled on first shift, they will go between basic and north hall, but there was not one scheduled on 5/1/24. In a subsequent interview on 05/02/24 at 10:01 AM, CNA S reported that she had not been scheduled to report to work at 4:00 AM on 5/1/24 to cover basic hall. CNA S reported that she arrived just before 5:00 AM on 5/1/24 to work on Rehab hall, so that she could get an early start on showers and getting residents out of bed just like she normally does. Review of Time Clock Record revealed that CNA S arrived to work that day at 4:54 AM, possibly indicating that ES G had given inaccurate information in the previous interview. Resident #10 Review of an Admission Record revealed Resident #10 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: depression, PTSD (post traumatic stress disorder) cerebral palsy (birth defect that causes disorder of movement, muscle tone and posture) and an overactive bladder. Review of Resident #10's Care Plan revealed, Focus: .has frequent bladder incontinence at night only and I am usually continent of bowel .Wears briefs at night .Date Initiated: 3/19/24 . In an interview on 04/30/24 at 01:34 PM, Resident #10 reported that staff frequently complained about being short handed and that it was worse during the night hours. Resident #10 reported that at times she pressed her call light to have her incontinence brief changed, and waited over 2 hours and stated, .I get sore .it burns . it soaks through my sheets .it doesn't make me feel very good . Resident #10 reported that half of the time the CNA's don't even know that her light was on when they come into the room, because they weren't carrying a call light phone with them. Resident #10 reported she waited from 5:20 AM to 8:00 AM that day for her call light to get answered, and the whole time she laid in a wet brief. Resident # 33 Review of a Minimum Data Set (MDS) assessment for Resident #33, with a reference date of 11/17/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #33 was cognitively intact. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/30/24 at 11:05 AM, Resident #33 reported that the facility had decrease the amount of CNA's per hall and now she has to wait longer for cares. Resident #33 reported that she prefers to get out of bed at 10:00 AM, but that on the weekends sometimes had to wait until 2:00 PM. Resident #33 reported that CNA's will often use the lift with 1 person because there's no one else to help. Resident #33 reported that when they pull the shower aide to help on the floor, then she does not get a shower. In an interview on 05/01/24 at 08:39 AM, Resident #33 reported that there was no CNA from 4:00 AM - 6:00 AM that day, and the nurse on the hall does not help with rounds, and was also responsible for another hall on the other side of the facility. Resident #41 Review of an Admission Record revealed Resident #41 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke and paralysis (inability to move body). Review of Resident #41's Kardex (direct care guide) revealed, .Bladder/Bowel: Brief use: The resident uses adult disposable briefs. Goal of check/change Q2-3hrs (every 2-3 hours) & PRN (as needed) . In an interview on 04/30/24 at 10:30 AM, Resident #41 reported that he has a friend that comes in to shave him and cut his nails and stated, .I don't think the facility has enough people to do those things . Resident #41 reported that day third shift had provided incontinence care only one time and the CNA had to do it by herself because she couldn't find anyone to help. Resident #41 reported that it is not safe to roll him in bed without someone on the other side to keep him from falling off the bed and stated, .but she used all of her power to hold me . In an interview on 05/01/24 at 12:11 PM, Resident #41 reported that he received incontinence care at 11:30 PM by 2 CNA's and then not again until 6:00 AM when the shower aide came to get him for a shower. Resident #41 reported that he was supposed to have his shower the day before (4/30/24), but the shower aide was pulled to work on the floor. Resident #41 reported that CNA V came in that morning and told him that she would come change him when she was done with the other residents and stated, .the last time I was changed was 6:30 AM with my shower .they are short staffed .they told me 2 or 3 people called in today . In an interview on 05/01/24 at 01:04 PM, CNA V reported that she would be doing cares on Resident #41 as soon as she could and stated, .there's still a couple people ahead of him . During an observation on 05/01/24 at 01:33 PM, CNA V reported that she had to go retrieve linens from the laundry room for Resident #41. At 1:37 PM CNA V entered Resident #41's room and told him that she was waiting for CNA MM to come from another hall to assist her. At 1:41 PM CNA MM arrived to assist with Resident #41's care. CNA V detached Resident #41's brief and it was noted soaking wet with urine and dried BM on his buttocks. In a interview on 05/01/24 at 01:53 PM, CNA V reported that she usually tried to get to Resident #41 before lunch, but she had to wait for help. CNA V was visably frustrated and reported that she started the day on another hall for the first hour and then was pulled to the basic hall because someone called in. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/02/24 at 09:30 AM, Resident #41 reported that he does not refuse incontinence care, and knows that staff should come in every 2 hours and stated, .last night no one came until 5:00 AM . 46999 Resident #55 Review of an Admission Record revealed Resident #55, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #55, with a reference date of 2/9/24 revealed the resident was not able to complete a Brief Inventory for Mental Status assessment due to inability to make herself understood. Section GG of the MDS revealed Resident #55 required maximal assistance (helper does more than half the effort) for eating, toileting, dressing, and personal hygiene. Review of a Kardex (a summary of care instructions) for Resident #55 revealed the resident used adult disposable incontinence briefs, was to be checked for incontinence every 2 hours and changed as needed. During an observation on 4/30/23 at 10:05am, Resident #55 sat in a wheelchair near the doorway of her room wearing sleepwear. Resident #55's hair was disheveled, appeared uncombed with the back of her hair pressed to her head. In an interview on 4/30/24 at 10:12am, Family Member (FM) AAA reported he visited Resident #55 3 times a week and had noticed in the last few months, Resident #55 was frequently not dressed when he arrived around 10:00am. FM AAA reported it had become increasingly difficult to find staff when Resident #55 needed assistance, and this resulted in delays in the resident receiving care. FM AAA also reported he noticed at times Resident #55 smelled of urine and had a saturated brief when he arrived. FM AAA stated I can smell that she needs to be changed right now. It looks like she hasn't been changed at all this morning. In an interview on 5/1/24 at 12:49pm, Certified Nursing Assistant (CNA) Q reported the facility had reduced the number of CNA's required for Resident #55's hallway in recent months. CNA Q reported since the reduction in staff, residents were experiencing longer wait times for care, it was not possible to meet all care needs, and staff felt increasingly stressed. In an interview on 5/2/24 at 9:07am, Registered Nurse (RN) LL reported staffing levels were too low to meet the needs of residents. RN LL reported some basic care needs like getting dressed in the morning were not being done on time. In an interview on 5/2/24 at 10:34am, Registered Nurse (RN) SS reported she observed residents, including Resident #55, not getting assistance with dressing before 10:00am, others experiencing long call light response times, and waiting for assistance with eating breakfast at 9:00am. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/2/24 at 11:31am, Certified Nursing Assistant CNA J reported the facility recently reduced the number of nursing staff and as a result, care needs were going unmet. CNA J reported due to the staffing reduction, resident care needs were going unmet because there was not enough time to complete the tasks. CNA J reported she could no longer provide individualized care because of time constraints. CNA J reported many members of the nursing staff felt very stressed and often had to choose between taking their breaks or meeting the needs of the residents. CNA J reported she was concerned about staff burnout due to the high level of stress. In an interview on 5/1/24 at 1:26pm, Registered Nurse (RN) JJ reported the facility had faced nursing staffing issues in recent months and openings in the schedule that were created by staff members calling in, went unfilled at times. In an interview on 5/1/24 at 12:24pm, Scheduler/Business Office (BO) G reported the facility had not been able to meet nursing staffing goals at times, primarily due to staff call-ins. BO G reported the facility did not pursue using agency staff to cover open CNA shifts unless there was more than 1opening, because the staff can get by when 1 CNA position is left open. According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 1589-1592). Elsevier Health Sciences. Kindle Edition.Time management, therapeutic communication, patient education, and compassionate implementation of bedside skills are just a few of the essential skills you need. It is important for your patients to leave the health care setting with a positive image of nursing and a feeling that they received quality care. Your patients should never feel rushed. They need to feel that they are important and are involved in decisions and that their needs are met . Review of the policy/procedure Staffing, dated 7/11/2018, revealed .Our facility provides adequate staffing to meet needed care and services for our resident population .Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. Certified Nursing Assistants (CNA's) are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan .

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 46999 Based on interview, and record review, the facility failed to complete annual performance reviews for 5 Certified Nursing Assistants (CNA's) (CNA's T, U, V, S, and XX) of 5 reviewed for regular in-service training, resulting in the potential for unidentified CNA performance concerns, a lack of training related to staff performance review outcomes, and the potential for unmet care needs. Findings include: In an interview with NHA A on 5/1/24 at 4:19pm, annual performance reviews were requested for CNA's T, U, V, S, and XX. Review of personnel files for CNA's T, U, V, S and XX, revealed no annual reviews were present for the past 12 months. Further review of the employee files revealed all CNA's had been employed by the facility for more than 12 months. In an interview on 5/2/24 at 1:41pm, Regional Human Resources Director (HR) RR reported the facility had recently determined that some nursing staff had not received annual performance reviews in the past year. HR RR reported the previous owner's of the facility had relied solely on competency training to ensure staff the necessary skills to perform their job duties. When further queried, HR RR reported CNA's T, U, V, S, and XX did not receive annual performance evaluations in the last 12 months. HR RR confirmed that performance reviews were important to ensure staff had the skills needed to complete their job duties. Review of a facility policy titled Annual Performance Evaluation Process with a reference date of 5/1/24 revealed: It is the protocol of this facility to provide an annual evaluation of all employee's performance .to ensure staff are aware of any deficiencies in their performance and .to develop a plan for continued improvement . Review of The Essentials Guide to Healthcare Performance Reviews, www.hrforhealth.com , 2024, revealed The benefits of healthcare performance reviews go beyond creating a better experience for your team .the most important (benefit) is performance reviews lead to improved performance .greater productivity and better overall experience for your patients.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review the facility failed to ensure that monthly medication regimen review (MRR) recommendations were documented in the resident's record and ensure timely physician response to pharmacy recommendations for 1 of 5 residents (Resident #9) reviewed for MRR, resulting in the potential for medication side effects and/or unnecessary medications. Findings include: Review of an Admission Record revealed Resident #9 was originally admitted to the facility on [DATE]. Review of Resident #9's current Physician Orders revealed, Xarelto Oral Tablet 20 MG (Rivaroxaban) (inhibits the formation of blood clots) Give 1 tablet by mouth at bedtime related to PAROXYSMAL ATRIAL FIBRILLATION (irregular heartbeat) Active 2/15/2024. Review of Resident #9'sPharmacy Regimen Review's dated 2/17/24 and 4/11/24 indicated that the pharmacist had submitted a follow up report with physician recommendations. Review of documents in Resident #9's health record, did not include the corresponding reports. In an interview on 05/02/24 at 02:08 PM, Social Services (SS) PP reported that monthly medication regimen reviews are completed by an outside pharmacy during the middle of every month. SS PP reported that the corresponding recommendations are sent via email and distributed to the physician for review, then given to nursing to implement, and lastly, scanned into the resident's record. SS PP reviewed Resident #9's records and did not find the corresponding recommendations for 2/17/24 and 4/11/24. SS PP reviewed her emails and found that the pharmacy had in fact sent Physician Recommendations for those dates via email and they should have been printed for the physician to address. SS PP reported that it did not look like the recommendations had been addressed. Review of Resident #9's Physician Recommendations dated 2/17/24 revealed, .resident is receiving oral anticoagulant Rivaroxaban 20mg QD (every day) for A-Fib (atrial fibrillation). Based on this indication, the resident's relevant clinical factors and the medications' safety/efficacy profiles, consider making the clinically appropriate therapeutic interchange to Apixaban .Beer Criteria: According to the 2023 Updated Beers Criteria, Rivaroxaban is a potentially inappropriate medication in older adults .this drug confers a higher risk of major and gastrointestinal bleeding in older adults . The document had noted been addressed or signed by the physician. Review of Resident #9's Physician Recommendations dated 4/11/24 revealed, .resident is receiving oral anticoagulant Rivaroxaban 20mg QD (every day) for A-Fib (atrial fibrillation). Based on this indication, the resident's relevant clinical factors and the medications' safety/efficacy profiles, consider making the clinically appropriate therapeutic interchange to Apixaban .Beer Criteria: According to the 2023 Updated Beers Criteria, Rivaroxaban is a potentially inappropriate medication in older adults .this drug confers a higher risk of major and gastrointestinal bleeding in older adults . The document had not been addressed or signed by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/02/24 at 02:23 PM, Regional Director of Clinical Services (RDCS) D, the recommendations from 2/17/24 and 4/11/24 were printed and given to Medical Director (MD) DDD to address, but that they had not been returned by the physician yet. RDCS D phoned the MD DDD while this surveyor was present and MD DDD indicated that he wanted the recommendations implemented as written by the pharmacist. RDCS D reported that MD DDD had physician recommendations printed in a folder and had not addressed them yet. RDCS D reported that the facility failed to follow up to ensure the recommendations were addressed timely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981 Based on observation, interview, and record review, the facility failed to 1.) maintain an Infection Prevention and Control Program. 2). follow the standards of infection control for hand hygiene, and glove use during incontinence care for 3 residents (Resident #41, #33 and #9) of 5 reviewed for infection control. 3). to ensure infection control practices were followed for adequate cleanliness of resident shared equipment (including but not limited to: transfer lifts, bath/shower rooms and commonly used surfaces) resulting in the potential for bacterial harborage, cross contamination, and the spread of disease to a vulnerable population. Findings include: In an observation on 4/30/24 at 10:39 AM., noted room [ROOM NUMBER] with a shared bathroom for 3 residents. The bathroom sink had 3 toothbrushes placed on the sink, which was visibly soiled. 2 of the toothbrushes were touching one another, the other was noted in a small pool of water on the sink base near the faucet. During an interview on 4/30/24 at 1:40 PM., Housekeeper (Hsk) Z reported housekeeper are responsible for cleaning resident rooms, common areas, and high touch surfaces. Hsk Z reported if nursing staff needs assistance with cleaning an item, or area housekeeping staff area available to assist. Hsk Z reported the housekeeping staff typically does not move resident personal hygiene items that are placed in bathrooms/bedroom unless asked to do so. Hsk Z reported the housekeeping staff will lift some items, and clean under or around them, but do not move any items from where they are placed by the residents or nursing staff. In an observation on 4/30/24 at 4:13 PM., noted a vitals machine near the medication cart parked next to room [ROOM NUMBER]. The base of the machine was noted to have dust, and debris on it. The blood pressure cuffs were noted to have crusted substances on them, and the finger probe (measures blood oxygen levels) was visibly soiled and had an accumulation of grime in the crevasses. In an observation on 4/30/24 at 4:17 PM., noted a seated scale parked next to room [ROOM NUMBER] in an alcove. The seat and back rest were visibly soiled. The frame of the scale had an accumulation of dust on it, and an overall soiled appearance. In an observation on 4/30/24 at 4:25 PM., noted a vitals machine on parked next to the medication cart by room [ROOM NUMBER]. The base of the machine was heavily soiled with dust and debris. the blood pressure (BP) cuffs were noted to have dried, crusted substances on the surface and the finger probe soiled was visibly soiled with grime. In an observation on 4/30/24 at 4:30 PM., noted a hoyer lift parked next to room [ROOM NUMBER]. The grab bar with a soft blue fabric cushion was visibly soiled with dried stuck on substances, and had an overall soiled appearance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 5/01/24 at 9:14 AM., noted a sit to stand lift parked outside room [ROOM NUMBER]. The base of the lift was visibly soiled with food crumbs, dust and debris. The knee pad (padded area residents shins are placed to stabilize during lift) was noted to be visibly soiled with dried crusted substance, and an overall soiled appearance. In an observation on 5/01/24 at 9:17 AM., noted a vitals machine on parked next to room [ROOM NUMBER]. The base of the machine was heavily soiled with dust and debris. the BP cuffs were noted to have dried, crusted substances on the surface and the finger probe soiled was visibly soiled with grime. In an observation on 5/01/24 at 9:24 AM., noted a sit to stand lift parked next to the shower/bathroom near room [ROOM NUMBER]. The base of the lift was heavily soiled with dust, debris and food crumbs. During an interview on 5/01/24 at 1:18 PM., Certified Nurse Aide (CNA) K nursing staff are suppose to wipe down/sanitize all resident shared equipment in between uses. CNA K reported at times it's difficult to do so, because sanitizing wipes are not always available in an easily accessible area to utilize. CNA K reported there should be a clear plastic bag with wipes hanging from/on the lifts. CNA K reported sometimes the wipes are there, and sometimes the bag is empty. CNA K reported nursing staff was short on most shifts so a lot of things do not get completed as should be. In an observation on 5/01/24 at 9:18 AM., noted a floor scale (large for wheelchairs) near room W402. The scale was noted to be heavily soiled with dust, debris and grime in the crevasses of the surface base of the scale. In an observation on 5/02/24 at 8:45 AM., noted a hoyer lift parked outside room [ROOM NUMBER]. The handle bar (black apparatus residents hold onto during lift) was noted to be soiled with dried crusted substances. Review of a facility Policy dated 7/11/2018 revealed: POLICY: It is the policy of this facility to provide supplies and equipment that are adequately cleaned, disinfected, or sterilized .PROCEDURE: 1. CLEANING: Supplies and equipment will be cleaned immediately after use. Gross blood, secretions and debris will be removed as soon as possible. Cleaning may be done in the resident's room or the soiled utility room. 2. DISINFECTION/STERILIZATION: Resident care equipment that enters normally sterile tissue or the vascular system, or through which blood flows, will be sterile. Respiratory therapy equipment that touches mucous membranes should be subjected to sterilization before each use; if not feasible, it will receive high-level disinfection 41027 In an interview on 05/01/24 at 12:42 PM, Registered Nurse (RN) II reported that she was transitioning into the Infection Preventionist (IP) position, but was still trying to complete her certification course and stated, .so right now I am just doing it partially .mostly working on the floor . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the Infection Control Interview on 05/02/24 at 10:10 AM, Regional Director of Clinical Services/Infection Preventionist (IP) D reported that she was typically present in the facility 2-3 days a week and Regional Nurse Consultant (RNC) TT was present the other week days to assist with the infection control program tasks. RNC TT was not a Certified Infection Preventionist. IP D reported that the facility had recently noticed an increase in UTI's (urinary tract infections) and changes in the continence status of residents. IP D reported that the Interim DON (Director of Nursing) B and DON C who was in training, would be starting staff re-education and audits of incontinence care and hand hygiene practices soon. IP D reported that they had not done any audits or bedside observations since they noticed the concern a couple weeks ago. Resident #41 During an observation on 05/01/24 at 01:41 PM in Resident #41's room, Certified Nursing Assistant (CNA) V and CNA MM were preparing to provide incontinence care. Both CNA's donned gloves, CNA V detached Resident #41's brief and it was noted soaking wet with urine. CNA V washed the front peri-area first, and then the CNA's turned Resident #41 onto his left side and there was dried BM (bowel movement) noted on Resident #41's buttocks. CNA V used multiple disposable wipes to remove the BM, handing them to CNA MM to throw away. CNA MM was also holding the resident to ensure that he didn't roll off the bed. CNA V reached into the nightstand to retrieve topical barrier cream, and applied it to Resident #41's buttocks, and the open wound on his right buttock. CNA V was still wearing the same gloves that she had donned at the start of care. Both CNA's then rolled the resident onto his back and put a clean brief on him. Both CNA's positioned Resident #41's arms back to his sides, adjusted his pillow, boosted him up in bed, covered him with a blanket, and used the bed controls, while still wearing the same gloves. The CNA's handled the resident, bedding, and other surfaces in the room with soiled gloves. In a interview on 05/01/24 at 01:53 PM, CNA V reported that she was not sure when gloves needed to be changed during incontinence care. Resident #33 During an observation on 05/01/24 at 01:06 PM, CNA W and CNA V were assisting Resident #33 in the bathroom. Resident #33 had a BM in the toilet. They used the mechanical sit to stand lift to assist Resident #33 to a standing position, CNA W used toilet paper with a gloved hand to wipe the resident's bottom, and then used the same hand to pull the resident's pants up, and guide her into her into the wheelchair and handle the lift during the transfer. The mechanical lift was noted to have a torn leather knee rest that was taped closed; the tape was worn and frayed. Resident #9 During an observation on 04/30/24 at 10:10 AM in Resident #9's room. There was a pile of linens near the wall that was observed to have a brown substance on them. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/01/24 at 8:23 AM, CNA W entered Resident #9's room, and the resident said I need to be changed. CNA W donned gloves, asked Resident #9 to roll to his side, removed the incontinence brief that was heavily saturated with urine on the bottom side, quickly applied a clean brief, and pulled the resident's pants back up with the same gloves on. CNA W did not wash the resident's buttocks or penis. Resident #9 asked CNA W if she had cleaned his butt and the CNA replied, You didn't have a BM (bowel movement). Resident #9 requested that the CNA wash him. With the same soiled gloves on, CNA W grabbed a disposable wipes out of the drawer and wiped over the resident's buttocks and then used another wipe and swiped down both sides of the residents groin fold. CNA W then exited the room, and there was a pile of soiled linens on the floor by the wall, as observed the day before. In an interview on 05/01/24 at 08:36 AM, CNA W reported that she doesn't nomally get time to care for Resident #9 until mid morning. CNA W reported that she wasn't going to wash Resident #9's peri-area because he did not have a BM, and then when she did wash him, she had forgot to clean his penis. Review of a facility policy Hand Hygiene last updated 3/24/22 revealed, It is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infection. PURPOSE: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: 1. Immediately before touching a resident. 2. Proper hand hygiene should be performed between all services to residents. 3. Before performing an aseptic task or handling of invasive medical devices. 4. Before moving from work on a soiled body site to a clean body site on the same resident. 5. After touching a resident or the resident ' s immediate environment. 6. After contact with blood, body fluids, or contaminated surfaces. 7. Immediately after glove removal. 8. To cleanse hands to prevent transmission of possible infectious material. To provide clean, healthy environment for residents and staff .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to ensure residents who were eligible for recommended vaccines were offered vaccination in a timely manner for 5 residents (Resident #9, #58, #56, #76, &#189) out of 5 residents reviewed for immunizations resulting in the potential for developing vaccine preventable disease. Findings include: In an interview on 05/01/24 at 12:42 PM, Registered Nurse (RN) II reported that she was transitioning into the Infection Preventionist (IP) position, but was still trying to complete her certification course and stated, .so right now I am just doing it partially . RN II reported that the Interim DON (Director of Nursing) B was responsible for tracking resident vaccinations. In an interview on 05/01/24 at 12:46 PM, DON B reported that she pulls reports from Michigan vaccine registry upon admission for residents, but did not know who was responsible to ensure resident immunizations are up to date. In an interview on 05/01/24 at 12:49 PM, Regional Director of Clinical Services/Infection Preventionist (IP) D reported that the facility had just started to look at resident immunizations, and she was not sure what the current status was. In the Infection Control Interview on 05/02/24 at 10:10 AM, IP D reported that immunizations are supposed to be part of the admission/nursing assessment, but was not being followed through with at that time. IP D reported that there are multiple resident immunizations not in compliance with regulations. The following records were reviewed with IP D: Review of Resident #58's Immunization Records indicated that he admitted on [DATE], but there was no record of pneumococcal and/or influenza vaccines, and no consents or declinations. Review of Resident #56's Immunization Records indicated that she admitted on [DATE], but nothing related to pneumococcal and/or influenza, and no consents or declinations. Review of Resident #9's Immunization Records indicated that he admitted on [DATE], but nothing related to pneumococcal and/or influenza, and no consents or declinations. Review of Resident #189's Immunization Records indicated that he admitted on [DATE], but nothing related to pneumococcal and/or influenza, and no consents or declinations. Review of Resident #76's Immunization Records indicated that she admitted on [DATE], but nothing related to pneumococcal and/or influenza, and no consents or declinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Immunizations-Pneumococcal dated 7/11/18 revealed, It is the policy of this facility that all residents will be offered the pneumococcal vaccines to aid in preventing pneumonia. 1. Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccines and when indicated, will be offered the vaccinations, unless medically contraindicated or the resident has already been vaccinated. 2. Before receiving the pneumococcal vaccines, the resident or responsible party shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccines. This information will be provided in the Consent to Administer Pneumococcal Vaccine. Telephone consent from the responsible party is acceptable if the resident is unable to sign. 3. Pneumococcal vaccinations will be administered to residents (unless medically contraindicated, already given or refused) per the medical director ' s standing orders .5. A resident ' s refusal of the vaccine shall be documented in the resident ' s medical record .8. Administration of the pneumococcal vaccinations or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to ensure residents' medical records included documentation that residents/resident representatives were educated, offered and/or received timely, the COVID-19 immunization as recommended by the Centers for Disease Control and Prevention (CDC) for 5 resident (Resident #9, #58, #56, #76, & #189) of 5 residents reviewed for immunizations, resulting in residents not receiving the Covid-19 immunization per CDC guidelines, the potential for incomplete vaccination, and the potential for serious illness and complications from COVID-19 (SARS-CoV-2). Findings include: In an interview on 05/01/24 at 12:42 PM, Registered Nurse (RN) II reported that she was transitioning into the Infection Preventionist (IP) position, but was still trying to complete her certification course and stated, .so right now I am just doing it partially . RN II reported that the Interim DON (Director of Nursing) B was responsible for tracking resident vaccinations. In an interview on 05/01/24 at 12:46 PM, DON B reported that she pulls reports from Michigan vaccine registry upon admission for residents, but did not know who was responsible to ensure resident immunizations are up to date. In an interview on 05/01/24 at 12:49 PM, Regional Director of Clinical Services/Infection Preventionist (IP) D reported that the facility had just started to look at resident immunizations, and she was not sure what the current status was. In the Infection Control Interview on 05/02/24 at 10:10 AM, IP D reported that immunizations are supposed to be part of the admission/nursing assessment, but was not being followed through with at that time. IP D reported that there are multiple resident immunizations not in compliance with regulations. Review of Resident #58's Immunization Records indicated that he admitted on [DATE], with one COVID-19 vaccine on 12/18/21, with no indication of a booster being offered, and no consents or declinations. Review of Resident #56's Immunization Records indicated that she admitted on [DATE], with previous COVID-19 vaccines on 6/3/21 and 7/1/21, with no indication of a booster being offered, and no consents or declinations. Review of Resident #9's Immunization Records indicated that he admitted on [DATE], had 3 COVID-19 vaccines on 11/4/21, 7/15/22 and 12/27/22, with no indication of a booster being offered, and no consents or declinations. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #189's Immunization Records indicated that he admitted on [DATE], with previous COVID-19 vaccines on 3/31/21 and 4/28/21, with no indication of a booster bieng offered, and no consents or declinations. Review of Resident #76's Immunization Records indicated that she admitted on [DATE], with previous COVID-19 vaccines on 3/12/21, 4/9/21, and 12/3/21, with no indication of a booster being offered, and no consents or declinations. Review of the facility policy Immunizations-COVID-19 Vaccine last updated 9/23/23 revealed, It is the policy of this facility that all residents will be offered the COVID19 vaccines to aid in preventing COVID19 infections and outbreaks. 1. Residents will be assessed for eligibility to receive COVID19 vaccines and when indicated, will be offered the vaccinations, unless medically contraindicated or the resident is up to date with vaccination, as recommended by CDC and approved by FDA (Food and Drug Administration) .2. Before receiving the COVID19 vaccines, residents or responsible parties shall receive information and education regarding the benefits and potential side effects of the COVID19 vaccines. Telephone consent from the responsible party is acceptable if the resident is unable to sign. a. In situations where COVID19 vaccination requires multiple doses, the resident or responsible party will be provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID19 vaccine, before requesting consent of administration for any additional doses .5. The resident's medical record will include the following documentation: a. That the resident/responsible party was provided education regarding the benefits and potential risks associated with the vaccine. b. Each dose of the COVID19 vaccine administered. c. If the vaccine was not received due to refusal or medical contraindications .8. Administration of the COVID19 vaccinations or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 35981 Based on observation, interview and record review, the facility failed to ensure residents had a functional nurse call system at all times resulting in the potential for serious psychosocial or physical harm for vulnerable residents who were often at times without a way to call for routine or emergency assistance. Findings include: Review of a facility Policy subject Call Light with an adopted date of 7/11/2018 revealed: POLICY: It is the policy of this facility to provide the resident a means of communication with nursing staff. PROCEDURE: 1. All facility personnel must be aware of call lights at all times. 2. Facility shall answer call lights in a timely manner. 3. Answer all call lights in a prompt, calm, courteous manner; turn off the call light as soon as you enter the room and attend to the resident needs. 4. Orient all new residents as appropriate to the call light at bedside as well as the call light in the bathroom and in the shower or tub rooms. 5. Nursing staff shall check all call lights daily and report any report defective call lights to the administrator/maintenance immediately for repair. 6. If a call light is not functional, evaluate and provide another means in order for the resident to call for assistance (i.e. bell) until the call light is fixed. 7. Be sure call lights are placed within reach of residents who are able to use it at all times. There is no reason to place the call light within the reach of a resident who is physically and cognitively unable to use the call light. 8. Be sure that when the call light is triggered, it will either alert the staff visually or audibly or both . In an observation on 4/30/24 at 11:10 AM., room [ROOM NUMBER]'s bathroom call light was hanging loosely from the wall. The call light apparatus was noted to be attached to the wall with medical paper tape. The call light was tested by pulling the cord, which did not trigger a sound. This surveyor walked down to an alcove area were the cell phone which was to display/sound when a call light or bathroom call light was utilized. The cell phone was observed to have no display of room [ROOM NUMBER]'s bathroom call light. During an interview on 4/30/24 at 11:30 AM., Certified Nursing Assistant (CNA) L reported the call light in room [ROOM NUMBER]'s bathroom has been like that for a long time CNA L reported the above the door call lights do not work, they do not make sound, nor do they light up. CNA L reported the facility uses a wireless cell phone connection for their call light system. CNA L reported when a resident turns on their call light, it should go directly to the cell phone on each unit. CNA L reported each CNA used t o have their own individual cell phone which they carried on their person. CNA L reported some of those were dropped/broken, and or staff has accidentally taken them home, so currently the units each have one stationary cell phone in which staff have to walk up to and look at the screen to see the call lights for resident rooms that are on. CNA L reported due to wireless signal, and weak Internet, call lights often do not go to the cell phones. CNA L reported many residents complain about long call light wait times. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/30/24 at 4:20 PM., CNA P reported the phone she carried that alerted her to activated call lights did not work properly and this had been an ongoing problem. CNA P reported the call light alert phone frequently disconnected from the wireless internet and when it did so, she had no other way of knowing when a resident had activated their call light. CNA P reported residents had expressed anger and frustration when they experienced long call light response times that had resulted. In an interview on 5/1/24 at 12:49 PM., CNA Q reported the facility did not have enough phones for the call light system and that the phones frequently malfunctioned. CNA Q reported most of the time 2 staff members had to share a phone and it was left in the hallway workstation so both staff members could access it. CNA Q reported staff turned the volume all the way on the shared phone, but it was not always audible, and it frequently lost the connection to the wireless Internet so it would not alert staff to activated call lights. CNA Q reported the facility was aware of the problem for several months. In an observation on 05/01/24 01:41 PM., room [ROOM NUMBER]'s bathroom call light was hanging loosely from the wall. The call light apparatus was noted to be attached to the wall with medical paper tape. The call light was tested by pulling the cord, which did not trigger a sound. The call light did not trigger the cell phone in the alcove/cna desk area. In an interview on 5/01/24 at 1:45 PM., Registered Nurse (RN) LL reported the call lights have been an ongoing concern amongst resident and nursing staff. RN LL reported staff have to walk to the CNA desk area to view a cell phone that has the call lights that are triggered for each room. RN LL reported the internet in the facility loses connection often during the day (and night). RN LL reported it is extremely difficult because the nursing staff cannot see or hear call lights when they are triggered, so it is a constant issue and takes a lot of extra time to get to the cell phones, especially when nursing staff are covering more than one unit. RN LL reported the call light wait times are a common complaint and concern from residents, their families and staff. During an interview on 5/02/24 at 10:26 AM., CNA I reported the call light system does not always work and has glitches. CNA I reported nursing staff has to go into the corner office to see what call lights on are on depending on the unit they are assigned. CNA I reported a few halls have cell phones on the unit at the CNA desk. CNA I reported the cell phone signal inside the building is weak, and does not always work when the phone goes off-line from the Internet which was very slow too. CNA I reported the internet in the facility goes out often, and the call light system does not work the way it should. CNA I reported the residents are frustrated with the system, because it takes more time to keep going to an area to look and see what call lights are on, and if the information on the cell phone is correct, which in return takes us (nursing staff) longer to answer the residents call for assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation/interview on 5/02/24 at 12:41 PM., Maintenance Director (Mtn-D) GG reported the call light program used by the facility computerized system has been locked out. Mtn-D GG reported he has been unable to get the code/password to be able to get into the program and adjust anything. Mtn-D GG reported not being able to access the call light program inhibits the ability to properly audit, and be able to even check if and when the call light system throughout the facility is down/not active, especially if the internet is down, and or the cell phone signal. Mtn-D GG reported he was unaware of the broken call light in room [ROOM NUMBER]. Mtn-D GG reported typically staff who notice something broken, should be completing a work order for the issue, but it is clear whomever placed the medical tape over the call light box, did not do a work order and or inform him at the time it was noticed to be off the wall unit. 36221 In an interview on 5/1/24 at 3:55 PM, Licensed Practical Nurse (LPN) FF reported the facility uses a phone based call light system to identify residents who need assistance, and stated .Not all of those phones work . LPN FF reported the facility used to have a phone for every staff member, along with a monitor at the nurses station that would list activated call lights. LPN FF reported the monitors no longer work, and staff often have to share phones as many have gone missing. LPN FF reported there are often issues with the connection/Internet service, and stated .When the Internet is not working we do rounds to check the call lights . and identify which residents need assistance. In an interview on 5/2/24 at 9:54 AM, Certified Nursing Assistant (CNA) S reported the facility uses a phone based call light system to identify residents who need assistance. CNA S reported the facility does not have enough phones for all nurses/CNA's on the floor. CNA S reported there are often issues with the connection between the phone and the call light system. CNA S reported if the phone is carried around the facility, it will disconnect from the Internet and notifications for activated call lights will not be received. CNA S reported staff often have to share one phone between multiple employees. CNA S reported nursing staff will leave the phone in a central area, and staff will check the phone periodically for activated call lights. 41027 In an interview on 04/30/24 at 02:28 PM, RN KK reported that at times the call light phones do not connect to the internet and she will have to go phone to phone to see the call lights. RN KK reported that she used to be able to see the call lights on the monitor in the nursing office, but the monitor no longer works. During subsequent observations on 05/01/24 from 8:12 AM-8:22 AM there were 2 CNA's in the hall passing trays and 2 Activity staff in the hallway passing out calendars. Resident #9's call light was on this during this time. At 8:22 AM Registered Nurse (RN) KK walked down the hall and stated, I miss the old call lights, and then informed CNA W that Resident #9's call light was on. In an interview on 05/01/24 at 8:19 AM, Activity Aide (AA) ZZ reported that she is expected to help answer call lights, but that she doesn't know if a resident's call light is on until she goes into their room. AA ZZ reported that she does not carry a call light cell phone, so she does not get the alerts. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 05/01/24 at 8:22 AM, CNA V reported that she did not like the new call light system because half of the time the phone won't stay connected to the internet, and the monitor in the nursing office doesn't work anymore.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 81 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 05/01/24 at 08:15 A.M., An environmental tour of the facility Laundry Service was conducted with Director of Environmental Services BB. The following items were noted: Clean Laundry Room: 9 of 18 overhead 48-inch-long fluorescent light bulbs were observed non-functional. The return-air-exhaust ventilation grill was also observed heavily soiled with dust and dirt deposits. The flooring surface was further observed soiled with accumulated and encrusted dust and dirt deposits. Soiled Laundry Room: The flooring surface was observed soiled with accumulated and encrusted dust and dirt deposits. Director of Environmental Services BB indicated she would have staff thoroughly clean all surfaces as soon as possible. On 05/01/24 at 10:15 A.M., A common area environmental tour was conducted with Maintenance Director GG. The following items were noted: Visitor Restroom: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. 100 Hall Soiled Utility Room: The countertop laminate edge surface was observed missing. The missing laminate surface measured approximately 2-inches-wide by 36-inches-long. 1 of 2 overhead light assemblies were also observed non-functional. 200 Hall Janitor Closet: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. 300 Hall Shower/Bathroom: 2 of 2 return-air-exhaust ventilation grills were observed soiled with accumulated and encrusted dust and dirt deposits. The atmospheric vacuum breaker was also observed missing on 1 of 2 shower wand assemblies. The commode base caulking was further observed (etched, scored, stained, particulate). 400 Hall (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nourishment Room: The Toshiba microwave oven interior was observed (etched, scored, particulate). The damaged interior surface measured approximately 2-inches-wide by 4-inches-long, exposing the inner corroded metal subsurface. Tub Room: The spa tub water inlet surface was observed stained with iron and mineral (calcium and lime) deposits. Nurses Station: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. Resident Restroom: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. The commode base caulking was also observed (etched, scored, stained, particulate). Activity Room: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust and dirt deposits. 500 Hall Basic Nourishment Room: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. Main Lobby: The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust and dirt deposits. 600 Hall Clean Linen Storage Closet: 1 of 2 overhead light assemblies were observed non-functional. Janitor Closet: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust and dirt deposits. Resident Restroom: The commode base caulking was observed (etched, scored, stained, particulate). Shower Room: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust and dirt deposits. The atmospheric vacuum breaker was also observed missing on the shower wand assembly. On 05/01/24 at 12:55 P.M., An environmental tour of sampled resident rooms was conducted with Maintenance Director GG. The following items were noted: 101: The restroom commode base caulking was observed (etched, scored, stained, particulate). The restroom commode base was also observed heavily soiled with bodily fluid (urine) residue. The restroom return-air-exhaust ventilation grill was further observed soiled with accumulated dust and dirt deposits. The restroom hand sink basin was also observed draining very slow. The Bed A desk fan was additionally observed heavily soiled with dust and dirt deposits. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	108: The Bed B overbed light assembly was observed non-functional. The restroom return-air-exhaust ventilation grill was also observed soiled with accumulated dust and dirt deposits. 110: The restroom return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust and dirt deposits. The commode base caulking was also observed (etched, scored, particulate). 114: The restroom commode base caulking was observed (etched, scored, particulate). The restroom commode base was also observed heavily soiled with bodily fluid (urine) residue. 202: The restroom hand sink basin was observed draining very slow. The restroom return-air-exhaust ventilation grill was also observed soiled with accumulated dust and dirt deposits. 205: The Bed B overbed light assembly switch was observed broken and non-functional. 308: The restroom hand sink basin was observed draining very slow. The restroom commode base caulking was also observed (etched, scored, particulate). The restroom commode base was further observed soiled with accumulated bodily fluid (urine) residue. 309: The restroom commode base caulking was observed (etched, scored, particulate). The restroom commode base was also observed soiled with accumulated bodily fluid (urine) residue. The Bed A overbed light assembly was further observed non-functional. 402: The restroom return-air-exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits. 405: The restroom return-air-exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits. 408: The restroom return-air-exhaust ventilation grill was observed soiled with accumulated dust and dirt deposits. The commode base caulking was also observed (etched, scored, particulate). 501: The drywall surface was observed (etched, scored, particulate), directly behind the Bed A headboard. The damaged drywall surface measured approximately 4-inches-wide by 24-inches-long. 503: The Bed A oscillating floor fan was observed heavily soiled with accumulated dust and dirt deposits. 603: The flooring surface was observed soiled with accumulated dust and dirt deposits. 604: The Bed A overbed light assembly upper 48-inch-long fluorescent bulb was observed non-functional. On 05/01/24 at 02:23 P.M., An interview was conducted with Maintenance Director GG regarding the facility maintenance work order system. Maintenance Director GG stated: We have the TELS software system. Maintenance Director GG further stated: We have only had TELS for about two months. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/02/24 at 10:45 A.M., Record review of the Policy/Procedure entitled: Preventative Maintenance dated 04/12/2021 revealed under Policy: Each facility will have a preventative maintenance program in place that scheduled preventative maintenance on equipment and the physical plant. Record review of the Policy/Procedure entitled: Preventative Maintenance dated 04/12/2021 further revealed under Procedures: (4) The Maintenance Director is responsible to perform preventative maintenance on equipment and physical plant on a schedule which factors in operational activity and complies with applicable code requirements. On 05/02/24 at 11:00 A.M., Record review of the Policy/Procedure entitled: Physical Environment Housekeeping Guidelines dated 03/08/2021 revealed under Policy: To provide guidelines to maintain a safe and sanitary environment for residents, facility staff, and visitors. Record review of the Policy/Procedure entitled: Physical Environment Housekeeping Guidelines dated 03/08/2021 further revealed under Procedures: (9) The Administrator and Environmental Services Director will routinely make visual quality control observations to ensure that a high level of sanitation is maintained. On 05/02/24 at 11:15 A.M., Record review of the Direct Supply TELS Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns. 35981 In an observation on 4/30/24 at 10:39 AM., noted room [ROOM NUMBER]'s bathroom toilet caulking around the base of the toilet was heavily soiled. The caulking was discolored with a dark yellow and black stains. Noted under the sink 3 soiled coffee cups were on the ledge. The bathroom had a strong odor of stale urine. In an observation on 4/30/24 at 10:51 AM., noted room [ROOM NUMBER]'s bathroom toilet caulking around the base was visibly soiled with yellow and black stains. The outer front portion of the toilet bowl was noted to have a buildup of dried yellow urine. Noted the privacy curtain in the bedroom area was visibly soiled in various areas with multiple stains. In an observation on 4/30/24 at 11:00 AM., room [ROOM NUMBER]'s bathroom toilet caulking around the base of the toilet was heavily soiled. There was a strong smell of stale urine. The toilet bowl outside front area was noted to have feces on it. There was a thick buildup of dried urine around the base and bolts of the toilet. The wall next to the toilet where the toilet paper holder was attached, noted multiple areas of what appeared to be dried feces on the wall. In an observation on 4/30/24 at 11:10 AM., room [ROOM NUMBER]'s bathroom toilet seat was heavily soiled with both dried and wet urine on the seat. There was a strong smell of urine in bathroom. The base of the toilet had very thick caulking with dark black and yellow stains. The bed side table in room [ROOM NUMBER] was heavily soiled with dried food, dried cup marks, and food crumbs. The recliner in the bedroom was very heavily soiled dark stains, spillage and a foul odor. The metal door frame of bathroom was heavily corroded, approximately 1-4 inches from the floor upward was noticed exposing corrosion of metal edges, chipped paint, and a buildup of dirt and grime. In an observation on 4/30/24 at 11:36 AM., noted the bathroom in room [ROOM NUMBER]. The toilet riser was heavily soiled with hair, wet and dried urine. There was a strong smell of urine noted in the bathroom, as well as the bathroom floor which was soiled and sticky. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview/observation on 4/30/24 at 1:40 PM., Housekeeper (Hsk) Z reported housekeeper are responsible for cleaning resident rooms, common areas, and high touch surfaces. Hsk Z reported if nursing staff needs assistance with cleaning an item, or area housekeeping staff area available to assist. Hsk Z reported resident rooms get cleaned once daily, and if nursing staff assists residents with toileting, the nursing staff are expected to clean up after the resident uses the bathroom, and or call housekeeping if they do not have time to clean something. Hsk Z reported the bathrooms should be cleaned and sanitized including both the inside and outside of the toilets, sweeping and mopping the floors in both resident rooms and their bathroom. Hsk Z reported (as this surveyor and Hsk Z) the observed bathrooms/bedrooms on the 300 unit should not be in the condition they are in, and she was unsure why they had not been properly cleaned. In an observation on 5/01/24 at 8:50 AM., room [ROOM NUMBER]'s bathroom toilet seat was heavily soiled with both dried and wet urine on the seat. There was a strong smell of urine in bathroom. The base of the toilet had very thick caulking with dark black and yellow stains. Next to the toilet on the floor was a pool of wet urine, and a large wad of yellow/wet toilet paper balled up. The bed side table in room [ROOM NUMBER] was heavily soiled with dried food, dried cup marks, and food crumbs. The recliner in the bedroom was very heavily soiled dark stains, spillage and a foul odor. In an observation on 5/01/24 at 1:35 PM., room [ROOM NUMBER]'s bathroom toilet caulking around the base of the toilet was heavily soiled. There was a strong smell of stale urine. The toilet bowl outside front area was noted to have feces on it. There was a thick buildup of dried urine around the base and bolts of the toilet. The wall next to the toilet where the toilet paper holder was attached, noted multiple areas of what appeared to be dried feces on the wall. In an observation on 5/01/24 at 1:41 PM., noted room [ROOM NUMBER]'s bathroom toilet caulking around the base of the toilet was heavily soiled. The caulking was discolored with a dark yellow and black stains. Noted under the sink 3 soiled coffee cups were on the ledge. The bathroom had a strong odor of stale urine. In an observation on 5/01/24 at 2:10 PM., room [ROOM NUMBER]'s bathroom toilet seat was heavily soiled with both dried and wet urine on the seat. There was a strong smell of urine in bathroom. The base of the toilet had very thick caulking with dark black and yellow stains. Next to the toilet on the floor was a pool of wet urine, and a large wad of yellow/wet toilet paper balled up (as previously observed at 8:50 AM). The bed side table in room [ROOM NUMBER] was heavily soiled with dried food, dried cup marks, and food crumbs. The recliner in the bedroom was very heavily soiled dark stains, spillage and a foul odor. In an observation on 5/02/24 at 11:36 AM., noted 4 large windows (1 upper & 1 lower for each of the 4 windows) to the outside back entrance of the facility, located in the hallway across from the sun room. The (2nd from the right facing outside) upper window had a large crack with linear cracking approximately 6-8 inches across in each direction in the right lower corner. The 4th lower window to the right (last in the series of the 4 windows) looking outside had 2 long cracks noted to be approximately 4-6 inches in length of the lower left area of the window. During an observation/interview on 5/02/24 at 12:41 PM., Maintenance Director (Mtn-D) GG reported the bathroom door frame for room [ROOM NUMBER] is in definite need of repair. Mtn-D GG reported he was not aware of the current condition of the the frame. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235311	A. Building B. Wing	05/02/2024

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility Policy dated 3/8/21 revealed: POLICY: To provide guidelines to maintain a safe and sanitary environment for residents, facility staff and visitors. PROCEDURES 2. Infection Control Procedures will be revised as necessary to maintain current infection control standards as determined by the local, state and federal agencies . 5. Housekeeping equipment shall be kept clean and in good repair. Daily cleaning will be the responsibility of the user. 6. Housekeeping personnel shall adhere to daily cleaning assignments developed so to maintain the facility in a clean and orderly manner Review of a facility Policy dated 7/11/2018 revealed: POLICY: It is the policy of this facility to provide supplies and equipment that are adequately cleaned, disinfected, or sterilized .PROCEDURE: 1. CLEANING: Supplies and equipment will be cleaned immediately after use. Gross blood, secretions and debris will be removed as soon as possible. Cleaning may be done in the resident's room or the soiled utility room. 2. DISINFECTION/STERILIZATION: Resident care equipment that enters normally sterile tissue or the vascular system, or through which blood flows, will be sterile. Respiratory therapy equipment that touches mucous membranes should be subjected to sterilization before each use; if not feasible, it will receive high-level disinfection