STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235331	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Howell	1333 W Grand River Howell, MI 48843

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to Intake #: MI00146952 Based on interview and record review facility failed to document and promptly resolve grievances reported to the facility staff for one (R79) of one Resident reviewed for grievances. Findings include: R79 R79 was admitted to the facility on [DATE]. R79's admitting diagnoses included heart failure, diabetes, muscle weakness, mild cognitive impairment, and legal blindness. Based on Minimum Data Set (MDS) assessment dated [DATE], R79 had a Brief Interview for Mental Status (BIMS) score of 14/15. R79 needed staff assistance with their Activities of Daily Living (ADLs) such as dressing, bathing, toileting etc. A complaint received by State Agency revealed that the concern (s) that were brought to the attention of facility staff were not resolved in a timely manner. An e-mail request was sent on 9/17/24 to the facility administrator to provide the grievances and the facility follow up for R79. Review of grievances and facility follow-up revealed that R79 had concerns about missing personal items that included a sweater and two other items (missing neck pillow and pillowcase) that were reported by the resident and the family on 7/21/24. The form was initiated by the Director of Social Services on 7/21/24. During an interdisciplinary team meeting on 8/16/24 (after 26 days) the resident/family had queried about the follow up. The form read spoke with family during care conference and went through the inventory list with family. Sweater that was lost is on the list. The other items are not able to replace by the facility. Plan: To replace lost sweater with a new sweater . The form revealed that resident/family were happy with the plan to replace the missing sweater and did not address any investigation or follow-up on the other missing items that were brought to the facility's attention. The form was completed and signed off on 8/16/24. The facility provided receipt for follow-up on the missing sweater revealed the order was placed on 8/14/24 (2 days prior to the scheduled meeting). (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R79's progress notes revealed a note dated 8/16/24 by the Assistant Nursing Home Administrator (NHA) read, Care conference held with family today to address concerns. Addressed concerns related meds (medications), care, missing items and ancillary appointments. It must be noted that facility did not provide any documentation on any of the grievances related to medication administration, care concerns, ancillary service (audiology, podiatry and or dental) appointment concerns that were brought to the facility's attention and acknowledged by the facility were not documented in the grievance form provided by the facility. Review of R79's Electronic Medical Record (EMR) did not reveal any further documentation related to the concerns that were communicated to the facility leadership during the meeting. An interview with R79's family member was completed on 9/17/24 at approximately 5 PM. They were queried about their concerns and the facility response. During the interview they reported they had brought up the care concerns, medication concerns and concerns related to their podiatry appointment during their meeting with facility staff. The concern about the missing sweater was brought the facility's attention several weeks prior to the meeting and it was not followed up and they had not received any call back from the facility leadership. When queried if they had attempted to call back and followed up, they reported that they had tried and were able to speak only with the social worker, not from administration. They had left messages and they did not receive any call back. They also reported that they were called in for this meeting and they were notified that the administrator would attend the meeting in addition to the rest of the facility leadership and ombudsman. They were out of state at work and had to take two days off to drive and attend the meeting. When they had arrived, they were notified that administrator was not able to attend the meeting. They confirmed that they did not receive any updates after the meeting. An interview was completed with the Director of Social Work (SW) G, on 9/18/24 at approximately 11:15 AM. They were queried about the facility's grievance process. They reported that the facility staff would initiate a grievance form if a concern was brought to their attention and they were followed up on the same day by the department leadership and they (grievances) were forwarded to the administrator. SW G was queried about the R79's concerns that were brought up during the meeting that were not documented in the grievance form and the delay in follow-up with the missing sweater. They had confirmed that they had discussed the resident/family's concerns related to care, call light response, appointment etc. and did not provide any further explanation on why they were not documented and did not provide any explanation why the missing item concern was not followed up timely and communicated. They also added that the administrator had to order the replacement sweater. An interview was completed with the facility administrator on 9/18/24 at approximately 1:10 PM. They were queried about the facility's grievance process and their follow-up. The Administrator reported that a concern/grievance from was initiated by any staff member who received a concern from a resident/family member. They were forwarded to the Administrator for review and they had assigned the department leaders for follow up and expected to resolve the concern within 72 hours. The Administrator confirmed that there were in the facility that day and they were not able to attend the meeting and the assistant Administrator was at the meeting. The Administrator was notified of the concerns with R79's grievance follow-up and the time frame and they reported that they understood the concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided document titled Complaint and Grievance Process with a revision date 1/1/22 did not provide any specifics the facility process to resolve any grievances and the time frame to resolve any grievances. The document read in part, 1. The facility will assist the individual with complaint and grievance process. 2. The facility privacy notice will clearly explain how an individual may file a complaint with the facility and that covered entity will not retaliate against the individual who files the complaint 3. The facility will receive and document complaints, but no response is required 4. Complaints and their dispositions will be documented if any .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review, the facility failed to ensure nursing staff adhered to professional standards for three (R81, R53 and R16) of seven reviewed for medication administration. Findings include: On 9/16/24 at approximately 10:24 AM, R81 was observed sitting in their wheelchair in their room. On their tray table was a prescription for Ciclopirox (a medication used to treat fungal infections). R81 was asked if they could identify the medication and whether they administered the medication on their own. R81 reported that staff administers the medication to their toes daily before putting on their socks. A second observation was made on 9/16/24 at approximately 11:21 AM and the medication Ciclopirox was still on R81's tray table. On 9/16/24 at approximately 11:25 AM, Nurse A was interviewed regarding R81's medication. Nurse A was asked if R81 was able to have the medication left unlocked in their room. Nurse A reviewed R81's medical orders and noted that they did not believe the medication had been ordered by the facility. Nurse A went to R81's room and the resident reported to Nurse A that the medication is usually administered by staff. A review of R81's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: coronary heart disease, renal failure, anxiety and diabetes type II. A review of the resident's Minimum Data Set (MDS) documented the resident had a Brief Interview for Mental Status (BIMS) score of 12/15 (moderately impaired cognition). The resident's record showed no order for the medication Ciclopirox. On 9/18/24 at approximately 12:01 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked about the facility's protocol regarding self-administration of medication and/or leaving medication in resident's rooms. The DON noted for those who wish to self-administer their own medication an assessment must be completed, if found able to administer, the medication will be locked in the nursing medication cart or kept locked in the residents' rooms. When informed that R81 had medication on their bedside table, the DON confirmed that the medication should not be left in their room. Review of the facility policy titled, Medication Administration documented, in part: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .wash hands prior to administering medication per facility protocol .observe resident consumption of medication .sign MAR (medication administration record) after administration . 49083 Resident 16 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed R16 was admitted to the facility on [DATE] with a history of repeated falls, stroke, recurrent urinary tract infections, rheumatoid arthritis, diabetes, hypertension, and ovarian cancer. R16 has a psychological history of anxiety, altered mental status, major depressive disorder, psychotic disturbance, including a personal history of suicidal behavior, including an attempt at the facility and recent ideations. A BIMS (Brief Interview of Mental Status) score totaled 11/15 indicating R16 had moderate cognitive impairment. On 9/18/24 at 8:54 AM, during introductions to R16, a clear medicine cup containing multiple pill medications was observed sitting on the bedside table. When inquired if medications are left for them to take daily, R16 replied it depends on the nurse. On 9/18/24 at 9:11 AM, the assigned Licensed Practical Nurse (LPN) M confirmed they left medications at the bedside and commented they trusted R16 to take them without staff presence. LPN M confirmed R16 did not have an order to self-administer and when asked if R16 should have an order, LPN M replied Probably. On 9/19/24 at 10:10 AM, the Director of Nursing (DON) was informed of the observation and conversation with LPN M. The DON acknowledged medications should never be left at the bedside without an order to self administer and will review with LPN M. 49272 R53 Medication Administration Observation On 9/18/24 at approximately 8:40 AM, RN Y was observed passing medications for R53. R53 was observed to drink approximately half of a Miralax (liquid laxative) dose. RN Y poured the remaining medication down the drain, in the resident's bathroom sink. When asked if that is how she would normally dispose of medications she responded yes. On 9/18/24 at 4:27 PM, the DON was queried on how she would expect liquid medications (such as reconstituted Miralax) to be disposed of, the DON reported medications should be disposed of in the proper way which would mean in a jug stored in the med room (specifically designed to destroy medications), the DON further stated medications should not be poured down the drain. Review of the facilities policy titled Medication-Destruction of Unused Drugs updated 1/18/24, documented in part .Unless otherwise instructed, combine tablets, capsules, liquids, and contents of vials and ampules in container with Kitty Litter or other agent such as a drug destroyer .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 Based on observation, interview and record review, the facility failed to provide activity of daily living care including showers for one (R27) of three residents reviewed for activities of daily living. Findings include: On 9/16/24 at 11:11 AM, R27 was observed in bed, lying on her back. R27 reported that they don't get showers like they should. R27 reported that their hair was saturated with sweat and when they ask staff for a shower or a bath, they tell her tomorrow, tomorrow. A review of the clinical record revealed R27 was admitted into the facility originally on 6/5/18 with the most recent re-admission on 3/12/23 with diagnoses that included: mixed incontinence, functional diarrhea, muscle weakness and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R27 was dependent for toileting hygiene and scored 14/15 on the Brief Interview for Mental Status (BIMS) exam (which indicated intact cognition). A review of R27's Treatment administration record (TAR) revealed that R27 should receive a bath or shower every Monday and Friday during the AM shift, however, only 2 showers and 2 bed baths had been documented for the 30 day look back period (8/23/24 through 9/18/24), no refusals were documented and 3 days had Response not required documented. On 9/19/24 at 8:26 AM R27 was observed in bed, lying on her back with her breakfast tray along the left side of the bed. R27 reported being soiled (with urine and stool), call light was on. On 9/19/24 at 8:37 AM, CNA FF and CNA GG entered R27's room to change R27's brief. R27's brief was observed to be soiled with non-formed stool. A large area of redness was noted in R27's groin folds, buttocks as well with a small open area that CNA GG reported was found on 9/18/24 by the wound team. RN HH later entered the room and applied zinc cream to R27's buttocks and reported that they would clarify with the facility's nurse practitioner what should be applied to groin folds. On 9/19/24 at 11:57 AM, the Director of Nursing (DON) was made aware of R27's allegation of not getting showered regularly and that the TAR confirmed that allegation (with only 4 of 8 showers documented for a 30-day period). The DON reported that they would review the CNA's (certified nursing assistants) task documentation and report back if she is able to find any additional showers or baths documented, DON further stated that the nursing staff should follow up with the CNA's if the showers are not being documented regularly. On 9/19/24 at 1:50 PM, the DON reported that they were unable to find any additional documentation of showers/baths and confirmed residents should receive showers or baths twice weekly.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to Intake #MI00146952 Based on observation, interview, and record review, the facility failed to obtain a podiatry appointment as ordered after an infection for one (R79) of one Resident reviewed for foot care. This deficient practice has the potential to deteriorate the mobility and overall wellbeing of the resident. Findings include: A record review revealed that R79 was admitted to the facility on [DATE]. R79's admitting diagnoses included heart failure, diabetes, muscle weakness, mild cognitive impairment and legal blindness. Based on the Minimum Data Set (MDS) assessment dated [DATE], R79 had a Brief Interview for Mental Status (BIMS) score of 14/15. R79 needed staff assistance with their Activities of Daily Living (ADLs) such as dressing, bathing, toileting etc. and for their mobility. An initial observation was completed on 9/16/24 at approximately 1:10 PM. The first part of the observation was completed from the hallway outside of R79's room. A CNA (Certified Nursing Assistant) was observed assisting R79 from bathroom to their recliner chair with their walker. The surveyor visited R79 after. R79 was observed in their room sitting in their recliner chair. During this visit R79 reported that they were waiting to see a podiatrist. They were notified that the facility had a podiatrist. They were a diabetic, and concerned about their foot. They were not seen last time when the podiatrist was at the facility and they were not sure why. Review of R79's physician orders revealed a physician order for podiatry consult dated 8/6/24 and it showed as completed. R79's clinical record did not have any evidence that R79 had a podiatry consult. Review of R79's progress notes revealed a practitioner note dated 8/5/24 that revealed that R79 was seen for left foot pain with swelling, and had ingrown toenails. The note read Patient states she will have podiatrist appointment for ingrown toenails order Bactrim (antibiotic) BID (twice a day) for 7 days .patient states toe pain not well controlled. A nursing progress note dated 8/5/24 at 15:36, read in part, Pain and swelling in left lower leg and foot, middle toe, red tender and swollen .Bactrim DS (antibiotic) Q (every) 12 Hrs (hours) x 7 days for infected toe/ingrown toenail .x-ray to left foot ordered. Further review of practitioner progress notes revealed a note dated 8/6/24 that read, Patient reports did not have podiatry consult, prefer in house treatment. Order podiatry consult for ingrown toenails. R79 was ordered to have an ultrasound of the left lower extremity due to continued swelling while they continued to receive antibiotics for the left toe infection. X-rays and the ultrasound were negative. Nursing progress notes dated 8/11/24 at 11:23 read, left foot slightly swollen . and antibiotic was completed on 8/12/24. There was no evidence on the EMR (Electronic Medical Record) that R79 had a podiatry follow-up. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress note dated 9/17/24 at 14:54 revealed that R79's daughter had concerns with right foot pain. Another physician order dated 9/17/24 read, podiatry consult for overgrown toenails . R79 had been waiting to see podiatrist (for over 40 days) since the initial order related to left foot pain (on 8/6/24). An interview was completed with the family member of R79 on 9/18/24 at approximately 5 PM. During the interview they reported they had a meeting with facility team prior to their admission to the facility. During the meeting they were notified that facility had a podiatrist and they would see the resident if they needed any service. They had been waiting to see the podiatrist since the left foot pain started and they were concerned as R79 was a diabetic. They added that they would have to make an appointment with the community podiatrist. During an interview with the facility appointments/transport coordinator (TC) L on 9/19/24 at approximately 10:30 AM. They had confirmed that they had scheduled the appointments for podiatry services. They were queried about R79's order to see the podiatrist. They reported that they received an order on 9/17/24 and they were going to schedule an appointment and the next scheduled visit was on 10/11/24. They were queried about the order from 8/6/24 and why they were not seen during the August visit. They reported that they were not aware of the order and they had obtained the consent on 8/27/24. They added sometimes those orders fall off after few days on their EMR. When queried why R79 was not provided with the consent when R79 was admitted and they had requested the facility services. TC L reported that Residents were signed up for ancillary services after they were a long-term resident for insurance reasons and did not provide any further explanation. An interview with Director of Nursing (DON) was completed on 9/18/24 at approximately 3:20 PM. The DON was queried about the podiatry appointment. They reported that the staff member TC L was scheduling the appointments, if they were not able to see the facility podiatrist or were not able to wait related to their condition, the facility would make arrangements to see a community podiatrist. The DON was queried about the order for R79 dated 8/6/24 and why it showed on as completed on the EMR when R79 did not have any podiatry visit. They reported that they were not sure what had happened. They added that they were seen and followed up by their practitioner. When notified of the concern related to timeliness of follow up they reported that they understood the concern. An email request for facility policy on ancillary services (podiatry) was sent to the facility administrator on 9/18/24 at 2:45 PM and was not received prior to survey exit.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #'s MI00146852 and MI00146901. Base on observation, interview and record review, the facility failed to ensure a timely investigation of a fall, complete a safe transfer, provide urinary assistance per the plan of care and provide appropriate supervision and interventions to prevent falls for two residents (R35 and R119) resulting in R119 sustaining an acute subcapital left femoral neck fracture. Findings include: On 9/16/24 a concern submitted to the State Agency was reviewed which alleged R119 had a fall with a fracture and the facility delayed in documenting and assessing R119 for injuries. On 9/17/24 the medical record for R119 was reviewed and revealed the following: R119 was initially admitted to the facility on [DATE] and had diagnoses including Difficulty in walking, Restlessness and Agitation and Chronic obstructive pulmonary disease. A review of R119's MDS (minimum data set) with an ARD (assessment reference date) of 6/9/24 revealed R119 needed assistance from facility staff with most of their activities of daily living. R119's BIMS score (brief interview for mental status) was three, indicating severely impaired cognition. A review of R119's comprehensive plan of care revealed the following: Focus-Resident is at risk for falls/injury related to: cognitive deficits, history of falling, visual deficits, takes psychotropic medications, and weakness Bed Modification: Patient prefers his bed against the wall. Date Initiated: 10/04/2023 . Interventions:-Frequent rounding while in resident room. Date Initiated: 09/09/2024 .Focus-Resident has an ADL (activity of daily living) self-care performance deficit related to: cognitive deficits, visual deficits, weakness, and difficulty in walking Date Initiated: 10/04/2023 .Interventions-TRANSFERS: 2 person assist. Date Initiated: 10/04/2023 . A review of R119's progress notes revealed the following: 9/3/2024 .Date of Service: 9/3/2024. Visit Type: Acute. Chief Complaint: Pain left hip. History of present illnesses: General: [AGE] year-old male with past medical history significant for diabetes dementia A. fib (Atrial fibrillation) pneumonia. Pt (Patient) is seen today per nursing requested for pain on the left hip. There was no reported of fall. Per nursing pt started to c/o (complained of) pain this morning. Pt alert but confuse, baseline, did not remember of fall .Assessment and Plans-Pain in left hip: Ordered X-ray left hip, right hip, lumbar, and left femur. Ordered tramadol 50 mg (milligrams) q6 hrs prn (every six hours as needed) for 1 wk (week). continue to monitor . 9/3/2024-Nurses' Notes: Writer called to resident room for evaluation related to resident indicating left leg pain and declining to get out of bed. Resident observed in bed, alert to baseline. C/O left upper leg pain and left hip pain. Resident stated to writer I fell . Resident assessed, unable to lift left leg off bed, left hip and upper leg painful to palpation, resident with facial grimacing, unable to determine any leg shortening or rotation, resident unable to lay flat due to increase in pain . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A SBAR (Situation, Background, Assessment, Recommendation) Communication Form with an effective date of 9/3/24 that was completed by R119's day shift nurse on 9/3/24 at 09:34 revealed the following: Request 4. Nursing Notes: VS (vital signs) and neuros (neurocheck) unremarkable and baseline. Writer attempted medication administration, resident declined medication, which is unusual for resident. When resident asked why he declined medication, he was unable to answer. A&O (alert and orientated) to self and baseline, moments of confusion, poor historian, usually follows commands. When asked if resident has pain, he initially declined pain. When resident was asked to sit up, he verbalized 'give me a hand.' When assistance was given, resident shouted out in pain. Assessment revealed left hip and left lower back pain. Resident unable to raise left leg off bed. Any movement of hip caused pain, but resident could not quantify pain, although using Wong-Baker it was 0 at rest, and 9/10 with movement. Declined to be rolled or changed. Left hip was externally rotated, it appeared shortened compared to right leg, although resident was poorly positioned in bed during assessment, then resident declined to reposition self or allower <sic> staff to reposition, and declined further assessment. Declined breakfast, which is unusual for resident since he baseline requests more that one breakfast and eats 100% of his breakfast. No bruising at left hip site. Verbalized he did not fall, verbalized he did not hit head. Dx. (diagnosis) Dementia, Provider [name of medical provider] on unit for evaluation. Ordered STAT hip and lumbar x-ray. DPOA daughter [name of DPOA] verbalized she instead wanted resident sent to [local hospital] immediately 9/7/2024-Nursing Evaluation Summary: Resident came back from [local hospital] via EMS (ambulance) at 1600. Residents principal problem is a closed displaced fracture of left femoral neck. Incision is 20 1/2 inches long with dressing intact and dry. Follow up with ortho (orthopedic) in 1 week to have post-op incision checked. Foley catheter in place with orders for follow up with urology in two d/t (due to) failing voiding trial Resident only complains of pain upon movement. Respiration equal and unlabored 9/9/2024 .Progress Notes-Date of Service: 9/9/2024 .History of present illness-General: [AGE] year-old male with past medical history significant for diabetes dementia A. fib pneumonia. Pt is seen today for re-admission. Pt sent to hospital for left hip pain. Pt found to have subcapital left femoral neck fracture. Pt underwent left hip hemiarthroplasty .Assessment and Plans- Risk of Complications and/or Morbidity or Mortality of Patient Management: moderate .Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing: PT/OT, monitor site for s/s of infection(drainage, edema, redness) F/u (follow-up) with orthopedic sx (surgery) as recommended . A review of the facility investigation and statements from staff pertaining to R119's fractured femur identified on 9/3/24 revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A statement from CNA (Certified Nursing Assistant) O (CNA O) on 9/5/24 who was identified as one of the CNA's who worked the midnight shift from 9/2/24 through 9/3/24 revealed the following: I worked on South. I work 11pm to 7am. I worked with [CNA S] and [Nurse R]. [R119] was sleeping when I arrived, and stayed asleep. I went on lunch around 04:10. I found him on the floor, [CNA S] was on lunch. He was behind bedroom door, hand was sticking out from the door. He was on his left side, his head was in the corner. I don't recall if he said anything to me. I called for [Nurse R] and said '[R119]'s on the floor'. We two person lifted him onto the bed, [R119] then said he was trying to go to the bathroom. He was complaining of left leg pain. The Nurse educated him, she didn't see any injury. The Nurse and I attempted to assist him to the bathroom. He couldn't stand, I couldn't find a urinal so I grabbed a cylinder. [CNA S] entered room right after he was done urinating. When he was on the floor, his bed sheet was wrapped around his feet. Until about 0600 he kept yelling for help, we kept checking on him. I texted [CNA S] at 03:40 that a resident fell . A statement from Nurse R on 9/5/24 who was identified as the Nurse assigned to R119 on the midnight shift from 9/2/24 through 9/3/24 revealed the following: I got to work around 2:30pm, I was on South. [R119] as his normal self. He gets meds early afternoon, and evening meds. I'm not sure when he went to bed. Wandered into the hall around 11pm. I redirected him back to his room. I didn't see him get up at any other point during the night. I checked on his roommate around 1am, [R119] was sleeping. I was not notified he was having any pain. When I gave report to day shift, I;I'm pretty sure he was still in his room A statement from CNA S on 9/5/24 who was identified as another CNA assigned to R119's unit on the midnight shift from 9/2/23 through 9/3/24 revealed the following: Worked on South. [R119] went to bed around 0200 on 9/3. I went to lunch around 03:15, returned to unit quarter to 4. I go outside on my lunch. [CNA O] texted me around 3:30 that he fell . I returned to the unit, [CNA O] and [Nurse R] were assisting [R119] with the urinal. He never asks for help. Kept going into his room to check on him, he was talking and wanting 'the guys' to help him fix something. I work 7pm-7am . A second statement from CNA O on 9/10/24 recorded by the Assistant Administrator during their final interviews revealed the following: During an interview with employee [CNA O] regarding a resident investigation, employee stated that when she found the resident on the floor, she immediately began texting her counterpart [CNA S] who was on break at the time. Writer asked why her immediate thought was to text her counterpart and not assist the resident, she stated that she always let's her partners know when something happens to a resident. Writer then asked what happened. [CNA O] stated she went and got her Nurse [Nurse R] in the common area to assess the fall. She stated resident was having a hard time walking to the bathroom, so they stood him to use the urinal. Writer then asked [CNA O] if the resident was showing signs of pain and distress and having a hard time sanding <sic> which she stated that she noticed, why would she make him stand to use a urinal since a urinal can be used lying or sitting. She stated, 'Oh yeah, I guess you're right.' She stated that they proceeded to help him use the bathroom in the urinal or cylinder. [CNA O] also stated that resident continued to need two people to assist him throughout the night and yelled out in pain. When asked why she didn't report it to another Nurse if she didn't feel confident that her Nurse had reported the fall or was doing the 'right thing' on behalf of the resident, she stated she didn't know she could and didn't know that CNA's did fall charting or behavioral charting. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/18/24 at approximately 11:05 a.m., the Director of Nursing (DON) was queried regarding their investigation of R119's fall during the early morning hours on 9/3/24. The DON stated that they were notified by the day shift Nurse T in the morning of 9/3/24 that R119 had been presenting with pain in their left leg. The DON indicated they assessed R119 at that time and then asked Nurse T to call the medical provider and get an order for an X-ray. When Nurse T notified the family of the change in condition they requested him to be sent out to hospital instead of having the in-house X-ray completed. The DON indicated that through their investigation, it was revealed that CNA O never informed Nurse R of R119's fall and had assisted R119 back into bed by themselves which was against facility policy. The DON indicated that CNA O should have had Nurse R assess R119 for any injury and then together they could have transferred them with the mechanical lift back into the bed. The DON also reported that after the fall, CNA O transferred R119 into a standing position to use a urinal without getting anyone to assist them and without Nurse R having had a chance to assess them. The DON reported that CNA O had multiple inconsistent reports of the incident and that they had filled out 15 minute check documentation for monitoring R119 that night and that no fall was indicated on the checks when CNA O had found R119 on the floor. The DON indicated that disciplinary action was issued to all three staff members including CNA O, CNA S and Nurse R and that Nurse R was disciplined for not following facility policy on providing supervision to R119 at least every two hours and checking on them. On 9/18/24 at approximately 4:10 p.m., Nurse R was queried regarding R119's fall during the midnight shift from 9/2 through 9/3/24. Nurse R reported that neither CNA O or CNA S had informed them that R119 had fallen in their room. Nurse R indicated they were never provided an opportunity to assess R119 for injury and that they were never consulted when CNA O transferred them back to bed by themselves. Nurse R was queired regarding assisting CNA O with R119 using the urinal later that night and they indicated they did not do that, and were unaware of any concerns regarding R119 that night. Nurse R reported that it was very unfortunate of what occurred, but that they knew nothing about R119 falling. On 9/18/24 a review of the disciplinary action forms titled Performance Improvement Form that were all dated for 9/9/24 for Nurse R, CNA O and CNA S revealed the following: Employee Name [Nurse R] .Reason for counseling/corrective action: Employee failed to check on resident every two hours per policy . Employee Name: [CNA S] .Reason for counseling/corrective action: Employee failed to report resident change to supervisor regarding resident complaint of extreme pain after unreported fall resulting in major injury to the resident . Employee Name: [CNA O] .Reason for counseling/corrective action: Failure to comply with 6.1 in employee handbook (1. violating resident right, failing to report to supervisor, 6. Falsifying documentation, 22. disruptive behavior) and 7.2 accidents to residents, 'if you suspect serious injury, do not move resident.' Employee failed to notify supervisor of resident change, didn't document resident experienced change in condition. Employee did not notify supervisor of resident fall that resulted in major injury, employee improperly assisted resident off the floor .Counseling sessions/corrective actions: Termination of employment . 34275 R35 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/16/24 at approximately 11:10 AM, R35 was observed lying in bed. The resident had bruising around their right eye as well as wraps around both their lower and upper right arm. The resident was alert but could not answer questions regarding the observation. A review of the R35's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Epilepsy, vascular dementia, and traumatic brain injury. A review of R35's MDS noted the resident had a BIMS (8/30/24) score of 0/15 (severely impaired cognition). The resident was noted to be incompetent to make their own decisions and had a court appointed guardian. Continued review of R35's clinical record and Incident/Accident (IA) documented, in part, the following: 6/17/24 -Encounter: Nurse stated resident had an unwitnessed fall . IA report: Incident witnessed: No-Resident unable to give description . Immediate Action: ensure that matt is next to bed at all times every time staff enters rooms, resident is moving objects . 6/18/24-Nurses Notes: Nurse heard a bang and went to resident's room. Resident was ambulating unassisted and was leaning against the wall began yelling to writer 'I told you that you should take a shot gun with you' .Resident yelling out nonsense .All discussions seem to center around violence, guns, cutting off heads, stealing and being 'stuck with broken needles' Resident gets very agitated . IA report: Resident lying on floor on the left side of the bed .R (resident) had removed brief and blue jeans were half pulled up. No footwear on .Notes: Resident has history of laying on floor .unable to communicate needs .Resident did not have night ware on .care plan updated to ensure resident is wearing sleeping clothes at night . 6/20/24-Nurses Notes: .Bump and bruising to right forehead and right eye . IA report: Observed lying on floor next to bed .It was observed resident's peg tube had dislodged .resident taken to ER (emergency room) resident experiences confusion and often unable to communicate needs .care plan undated with nonskid foot ware as resident allows. *The resident returned from the hospital on 7/4/24. 7/10/24 -Nurses Notes: Resident found on floor laying next to overturned wheelchair. Resident not able to verbalize how he got on floor .Resident had also pulled out all clothes in drawers and closets and threw them all over the room . IA report: Immediate action: Continuing to monitor resident to maintain his safety and staff safety .care plan updated to remove excess furniture . 7/11/24 - Nurses' Notes: Found resident on floor in room. Resident was laying on his back with pieces of blinds in his hand .also the bed control .Resident not able to tell how he got on the floor .Nursing management .were notified. IA report: .Immediate Action: Bed control removed from room .Called NP (nurse practitioner) on call and she suggested 1:1 sitter and maybe adding care plan .because of continuous falls . Called nursing management and notified them of NP suggestion and they stated they would bring it up in morning meeting .Notes .Care plan updated for provider to evaluate medications and add pain medication as indicated. *It should be noted there was no documentation in the resident's care plan that noted an intervention to provide a 1:1 sitter. 7/17/24- Nurses' Notes: .R35 appears as if he was eating chocolate ice cream due to residue on his hands and face and in his bed. Writer asked if he ate ice cream, and he states yes .unable to provide details .R35 is NPO (nothing by mouth) . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/18/24 - Progress Notes: .Fall 2x this morning . IA report(s): .9:00 AM .he was sitting against bed with wheelchair in reach .Witnessed: No .Immediate Action: Maintenance added another break to wheel of bed . IA report .10:10 AM . Housekeeper director called nursing staff to back common area on hall and stated resident fell .Incident witnessed: No .Immediate Action: reminded resident to lock wheels before transferring and to ask for assistance . 7/19/24- Pertinent Charting Behavior: .Resident spending most of time in room, occasionally upset because he wants to eat food . 7/23/24- Progress Notes: .R35 seen today for fall .Pt. attempted to transfer self from wheelchair to regular chair, missed it and fell to carpet floor . *No IA was provided for this accident. 7/25/24- Nurses' Notes: .found resident walking down hall naked from waist down .Continue to monitor . 8/1/24 - Nurses' Notes: .Resident was found at the end of his bed on the floor. Mattress was halfway off bed and resident went to floor off mattress .Maintenance request sent as urgent to place foot board at the end of the bed to prevent further falls . IA report: Was this incident witnessed: No . Immediate Action: .there is no foot at the end of the bed . 8/2/24- Nurses' Notes: Resident was demanding to call kitchen to get food and became very irate that he cannot have food by mouth . 8/8/24- Nursing Evaluation: .Resident has a history of frequent agitated behavior .Resident was also evaluated by speech and started on puree diet with 1:1 supervision . 8/8/24-Nurse's Notes: Walked into resident's room and found him bleeding from penis from foley catheter. Resident stated he had stepped on the bag, and it hurts .continued to monitor . 8/21/24-Nurses Notes: .Resident very agitated . IA report: .3:06 PM .Walked into room found resident laying on floor R35 totally naked feces over lower body on legs and back Was this incident witnessed: No . Immediate Action: .managed to walk R35 to bathroom . 8/21/24-Nurses'Notes: .Found resident on floor laying on top of blue foam cushions. Resident was totally naked with feces noted all over lower extremities . IA report: .11:55 PM Was this incident witnessed: No Notes: resident experiences confusion, often doesn't ask for assistance .Resident was self-ambulating when he went to sit on the footrests of his wheelchair . 8/23/24-Pertinent Charting Behavior: Between 2 AM and 4 AM resident was seeking food. Went to all the carts, dining room, and onto unit 2 .Yelling I want food . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	8/29/24-Encounter: Resident fell to floor and hit back of head on floor. 2-inch laceration noted which will most likely need sutures. Ok to send to ED (emergency department) . IA report: Resident was walking and pushing his wheelchair attempted to redirect .he began running and fell .hit his right brow and lower eye lid on either the floor or the back of the wheelchair when he fell .Resident reported that he thought the nurse was going to try to give him a bolus tube feeding and was running away .Was this incident witnessed: No Immediate Action Taken: resident would be sent to ER for assessment .d/t (due to) 2 recent falls with head involvement .skin tear flap hanging down from right lower eye lid .Staff have noted resident to be more difficult to redirect recently related to changes in tube feed administrative times .Care plan updated to staff to discourage resident from pushing wheelchair while walking as needed . 8/29/24-Progress Note: Resident returned from ER (emergency room) at 8:40 AM. 3 staples to back of head . 8/30/24-Nurse's Notes: Found resident at end of poppy hall, eating a cookie and trying to remove puddings from med cart . 8/30/24-Progress Note: EMS (emergency medical services) here to transport resident for psych evaluation . *It should be noted that the resident remained in the hospital through 9/9/24. Hospital records pertaining to the residents' psychological concerns were not located in the resident's clinical record. A request was made to provide the documentation. 9/12/24-Progress Notes: .R35 is seen today for fall. It was unwitnessed .found next to his bed . IA report: . was this incident witnessed: No .Notes: Care plan updated for sleep diary . 9/12/24-Nurses' Notes: resident opened up the food cart and removed tray and going down hall with food tray . 9/14/24-Pertinent Charting Behavior: .Resident took a plate of food from lunch caddie .Writer approached resident and he had a fistful of French fries and actively shoving them in his mouth .Writer convinced resident to spit out what he hadn't already swallowed .Resident was continuously leaving the hall in search of food or drinks . 9/15/24: IA report .10 PM .Was this incident witnessed: No .Notes: care plan updated to encourage resident to keep wheelchair within reach. 9/16/24-Progress Notes: .seen today for Slide off wheelchair twice this weekend . IA report: .1:48 AM . Resident was with a small cup of water while wheeling himself down the hallway. When staff attempted to get the cup, the resident became upset and threw the cup .followed him .when the resident went to transfer himself from his wheelchair to a chair he missed and fell to the floor Notes: .R35 recently returned from hospital stay where a diet order was in place for 1:1 assistance with meals .resident was drinking unsupervised .care plan updated for medication review. 9/16/24: IA report: 12:10 AM Was this incident witnessed: No .Notes: resident often chooses to self-transfer and has an increase in behaviors related to receiving enteral nutrition .Care plan updated for staff to encourage resident to be in common areas while awake on night shift and to offer 1:1 activity to resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of R35's care plans documented, in part, the following: Focus: Resident has an ADL (activities of daily living) self-care performance deficit .Interventions: Ambulation: walker or wheelchair (6/13/24) .Bed Mobility-1 person assist (4/22/24) .Eating -NPO at this time (4/29/24) .Transfers -1 person (4/29/24) . Focus: Resident is at risk for falls/injury related to potential seizure activity, history of falling, takes psychotropic medication and cognitive deficits .Interventions: .Discourage resident from pushing wheelchair while walking as needed (8/29/24) .Encourage resident to be in high visibility areas while awake (8/22/24) . Encourage resident to keep wheelchair within reach (9/16/24) .Encourage resident to lock wheelchair breaks before standing up (8/29/24) .Frequent rounding while resident in room (6/14/24) .Sleep Diary (9/12/24) .Staff to ensure bed height to be at residents knee level .(6/14/24) .Staff to ensure wheelchair is locked when resident not in it (7/19/24) .Encourage resident to keep needed items within reach (4/22/24) .Encourage resident to use call light (4/22/24) .Encourage the resident's room is free from accident hazards .(9/15/24) . Non-skid footwear to reduce the risk of slipping .(6/20/24) . Focus: Resident is at risk for altered nutritional status related to: Enteral nutrition via PEG .NPO .Chooses to consume orally despite NPO/pleasure feeds offered during therapeutic setting .Interventions: Keep all food off hallway and dinning room when resident is up. Resident known to get into uneaten food (8/17/24) . Resident is NPO (4/24/24) . Review of a document titled, Department of Health and Human Services - Comprehensive Level II Evaluation (8/6/24) .reported, in part, the following: .R35 .Diagnoses: Schizoaffective disorder, Bipolar type-primary .Recommendations: R35 was living in a group home .but is reportedly unable to return there due to his feeding tube. From reports, it appears R35 would be more satisfied if he were able to have small amounts of pleasure foods. This is allowed in the results of his swallow study, yet the nursing facility reported that he must be on hospice to receive this . A swallow study dated 6/19/24 noted the following: .Recommendation .Supervision Swallow Recommendations: 1:1 .Position Swallow Recommendation: Upright 90 degrees .Swallow Precautions Recommendations: Small bites of food .Discharge Recommendations: NPO with PEG as primary source of nutrition, hydration, medications. R35 may have bites of puree consistency foods for comfort . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/19/24 at approximately 10:36 AM an interview and record review were conducted with the DON. The DON was queried as to the multiple falls sustained by R35 and the interventions that were introduced to try to reduce them. The DON noted that the resident was very impulsive, non-compliant and had several behavior issues. The DON noted that initially they tried to remind the resident to utilize their call light, lock their wheelchair and wear proper footwear, but that did not always work. They further reported that were seeking to adjust the resident's medications to ensure they are getting a good sleep. The DON stated that R35's behaviors seem to get worse when they do not get their necessary sleep. In September 2024 they started to keep a sleep diary. The DON was asked why the facility did not follow the NP's recommendation (dated 7/12/24) that R35 receive 1:1 sitter due to excessive falls. The DON noted that they did not implement the recommendation and indicated that due to the resident's behaviors, including behaviors towards staff, that would require two staff to always assist the resident and the facility was not able to provide that care. The DON was asked about the resident's attempts to obtain food that led to falls and/or potential injury. The DON noted that they were aware the resident attempted to obtain food and on more than one occasion was able to grab and consume food. The DON was then asked if the resident required additional supervision to ensure the resident was not grabbing and consuming food on their own again. The DON noted that staff will try to redirect the resident if they are observed trying to obtain food, but again there is no direct 1:1 supervision currently being provided. The DON reported that they were trying to work with the resident's Legal Guardian to try to obtain permission to place the resident on Hospice so that they could have potential pleasure trays during meals, however the Guardian was not responsive to the request. The DON did indicate that the only person providing food was the Speech Therapist. On 9/19/24 at approximately 11:17 AM, an interview was conducted with Speech Therapist (ST) V regarding 1:1 feeding assistance for pleasure trays that may have the potential to reduce falls. ST V confirmed that they are the only person providing feeding assistance at this time and have not trained any further staff. They also noted that unless R35's Legal Guardian agrees to Hospice they do not feel comfortable allowing other staff to provide feeding assistance. On 9/19/24 at approximately 11:44 AM, an interview was conducted with the Administrator regarding R35's falls and attempts to obtain food. The Administrator reported that they were aware of the incidents and were trying to work with the Guardian as to whether they would agree to Hospice or palliative care for the resident. As to providing 1:1 supervision for R35, the Administrator noted that at this time they did not believe it was needed. On 9/19/24 at approximately 12:30 PM, an interview was conducted with the Ombudsman X. The Ombudsman reported that they were at the facility to discuss concerns brought up by R35's Legal Guardian. According to Ombudsman X, R35's Legal Guardian had reported concerns related to falls and the failure to feed the resident a pleasure tray without being a Hospice resident. Ombudsman X noted that the Legal Guardian reported that prior to admission to the facility the resident had minimal behavior issues and limited falls and felt that if the resident were to receive feeding it might limit falls and behavior issues. Review of the facility policy titled, Fall Prevention Program (10/26/23) documented, in part:; Policy: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls .Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review the facility failed to ensure oxygen was administered per Physician's order and the appropriate cannula was provided and changed for two residents (R149 and R112) of two residents reviewed for respiratory care. Findings include: R149 On 09/17/24 the medical record for R149 was reviewed and revealed the following: R149 was initially admitted to the facility on [DATE] and had diagnoses including Respiratory failure whether with hypoxia or hypercapnia, Hypoxemia, Pulmonary emphysema and Pulmonary edema. A review of R149's MDS (minimum data set) with an ARD (assessment reference date) of 7/11/24 revealed R149 needed assistance from facility staff with most of their activities of daily living. A Nurse Practitioner (NP) Evaluation dated 7/11/24 revealed the following: Date of Service: 7/11/2024 . General: [AGE] year-old female with chief complaint of shortness of breath. Patient was recently in the hospital for hypercapnia. Patient CO2 was 80. Patient seen and examined today and talked with her husband states that her breathing has become more rapid starting today. Her oxygen level was 94%. She denies any chest pain or tightness .Assessments and Plans .Risk of Complications and/or Morbidity or Mortality of Patient Management: moderate .Shortness of breath: Stat CO2, CBC (complete blood count), CMP (comprehensive metabolic panel) ordered. O2 nasal cannula 2L (liters per minute) If starts to decompensate, will send to ER (emergency room) . A Nurse Practitioner evaluation dated 7/12/24 revealed the following: 7/12/2024 .Date of Service: 7/12/2024. Visit Type: Follow Up .Pt (patient) seen and evaluated today for follow up on SOB (shortness of breath). She was hyperventilating yesterday and placed on 2L O2 (oxygen) NC (nasal cannula). Her husband states she seems to be having mental status changes again and seeing things that ares <sic> there which is what happened last time she has to go into hospital and CO2 was high . A review of R149's Physician orders revealed the following order with a start date of 7/11/24 and an end date of 7/11/24: O2 with nasal cannula at 2L (liters) STAT for SOB Further review of R149's Physician orders and administration records did not reveal any documentation that R149 was provided oxygen therapy past 7/11/24 per the NP evaluation on 7/12/24 On 9/17/24 at approximately 2:25 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the lack of oxygen orders and administration documentation after 7/11/24 and they reported that they would have to look into the concern. On 9/18/24 at approximately 10:27 a.m., during a follow-up conversation with the DON, the DON indicated that another order for oxygen administration should have been implemented and that it was missed. The DON indicated that they did not have any further documentation that R149 was administered oxygen therapy per the NP's evaluation on 7/12/24 after the initial order on 7/11/24. 49272 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R112 On 9/16/24 at 1:09 PM R112 was observed in their room, sitting in a wheelchair, doing a nebulizer breathing treatment. R112 reported that the nasal cannula provided by the facility does not fit and makes it difficult to breath. R112 reported that the facility was made aware upon admission. R112 further reported that they have been using their own home supply and is currently using her last one and has been for a couple weeks. R112's personal nasal cannula and the nasal cannula provided by the facility were observed. The nasal cannula provided by the facility had significantly larger nasal prongs that are further apart than the nasal prongs on R112's personal nasal cannula. On 9/18/24 at 11:44 AM, R112 was observed lying in bed, on her right side. R112 reported that they had notified both the Director of Social Work G and Central Supply Staff member EE. On 09/18/24 at 12:06 PM, an interview was conducted with Central supply staff member EE, who stated that they were aware of R112's request for a different nasal cannula and that they were made aware of the request last week. Central Supply staff member EE reported that they felt the request was based on personal preference, despite resident stating the nasal cannula supplied by the facility made it difficult for her to breath. Central supply staff member EE reported they requested a different nasal cannula from their supplier on Friday 9/18/2024, the supplier reported back that they would look into it. In an effort to get a proper fitting nasal cannula Central supply staff member EE reported that they would go to a local medical supplier and pick up something that day that works better for R112 (on 9/19/24 it was confirmed that R112 was still using their own personally supplied nasal cannula). On 9/19/24 at 11:48 AM an interview was conducted with the director of nursing (DON), when queried how often nasal cannulas should be changed they reported they would have to review the policy to confirm the exact timeframe. When asked how staff know to change it, they reported that it should be entered as an order instructing them to do so. The DON was informed at that time that there was not an order for R112 instructing staff to change the nasal cannula weekly or at all. The DON was additionally informed that R112 reported that the facility supplied nasal cannula makes it difficult for them to breath and central supply staff EE felt it was considered a personal preference. On 9/19/24 at 12:05 PM, the Director of Social Work G reported that they were made aware of R112's need for a different nasal cannula approximately two weeks ago. Social work G reported that Central Supply staff member EE was made aware before her. On 9/19/24 01:50 PM, the DON reported that they obtained an order from the facility physician to change the nasal cannula and confirmed it should be changed every week. On 9/17/24 a review of the clinical record revealed R112 was admitted into the facility on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Acute and Chronic Respiratory Failure with Hypercapnia, Chronic Respiratory Failure with Hypoxia, and Dependence on Supplemental Oxygen. On 9/17/24 a review of R112's physician orders revealed an order for Oxygen 3L via nasal cannula, continuous with a start date of 8/20/24. At the time of review there was not an active order instructing staff to change the nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Oxygen Administration updated 10/23, documented in part Staff shall perform hand hygiene and don gloves when administering oxygen or in contact with oxygen equipment. Other infection control measures include .Change oxygen tubing and mask/cannula weekly and as needed if soiled or contaminated.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure medically related social services were provided for two residents (R16 and R124) of two residents reviewed for Social Services. Findings include: R124 On 9/16/24 the medical record for R124 was reviewed and revealed the following: R124 was initially admitted to the facility on [DATE] and had diagnoses including Dementia, Restlessness and Agitation and Delirium. A review of R124's MDS (minimum data set) with an ARD (assessment reference date) of 6/29/24 revealed R124 required set-up assistance from staff. R124's BIMS score (brief interview for mental status) was three indicating severely impaired cognition. A review of R124's comprehensive plan of care revealed the following: Focus-Resident has impaired cognitive function related to: unspecified dementia with behavioral disturbance/hallucinations/delirium and BIMS score. Date Initiated: 06/27/2024 . A review of R124's demographic profile-facesheet revealed R124 did not have an appointed legal decision maker. Further review of R124's medical record did not reveal any legal guardianship or power of attorney documentation or any documentation that the process for legal guardianship had been started. A review of R124's Initial Social Service History dated 6/29/24 was conducted and revealed all the text fields were left blank and not filled out. On 09/19/24 at approximately 10:38 a.m., Social Service Worker H (SSW) was queried regarding the lack of a legal decision maker for R124 and why a mental capacity evaluation and advocacy for a decision maker had not been completed. SSW H indicated that they were going to try to get a capacity evaluation completed soon and were still waiting on documentation from the family for power of attorney. SSW H was queried why R124 did not have an initial social service assessment completed and they reported that it was missed and would have to get one completed. SSW H indicated that the assessment should have been completed within the first seven days of admission. SSW H reported they would have to call R124's family to follow up on power of attorney paperwork or start the guardianship process. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility document pertaining to the duties of the Social Service department titled Social Worker was reviewed and revealed the following: Summary: Provides psychosocial support to residents and their families Essential Functions: Provides direct psychosocial intervention. Performs resident assessments at admission, upon condition change and/or annually. Creates, reviews and updates care plan and progress notes. Provides direct psychosocial intervention. Coordinates resident visits with outside services,dental, optical, etc. Attends and documents resident counsel meetings. Assists resident's families in coping with skilled nursing placement, physical illness and disabilities of the resident, and the grieving process. Works with the patient, family and other team members to plan discharge. Conducts in-service programs to educate staff regarding psychosocial issues and patient rights. Supervises and guides Social Services Assistants. Performs other tasks as assigned 49083 Resident #16 Clinical record review revealed R16 was admitted to the facility on [DATE] with a history of repeated falls, stroke, recurrent urinary tract infections, rheumatoid arthritis, diabetes, hypertension, and ovarian cancer. R16 has a psychological history of anxiety, altered mental status, major depressive disorder, psychotic disturbance, including a personal history of suicidal behavior, including an attempt at the facility and recent ideations. A BIMS (Brief Interview of Mental Status) score totaled 11/15 indicating R16 has moderate cognitive impairment. On 9/18/24 at 8:54 AM, During initial introduction, R16 revealed that they were recently sent to the hospital for suicide comments and stated, All the Bosses sent me out because I said I had a plan to get out of here. What I meant is that I had a plan to go back to my home. I am on all these antidepressants because this place is so depressing. A historical record review revealed a suicide attempt in July 2023, R16 was found in this facility with a plastic bag pulled around their neck and tightening the bag as the staff tried to remove. R16 was evaluated and deemed incapable of making decisions regarding medical treatment by the attending physician and licensed psychologist. A progress note dated 9/4/24 at 2:40 PM, documented the Director of Social Work (SW) G was notified by staff that R16 was having suicidal ideations and had a plan. SW G informed the staff to transfer R16 to the hospital via Emergency Medical Services (EMS) and Police. On 9/18/24 at 3:00 PM, the Director of Social Work G was interviewed and confirmed they (G) was the responsible party for petitioning R16 to the hospital. When questioned about the progress note that R16 had a plan, SWG replied, I just assumed R16 was going to put a bag around their head like before. I removed their trash bins with the plastic bags, and any obvious sharp objects. I did not go into their drawers because that is a dignity thing. When questioned about R16's readmission, after SWG petitioned them, SWG was unaware of R16's evaluation, medications/changes, or follow-up appointments. When asked if there was any paperwork from the emergency room (ER), SWG explained there was not any and if there was any, R16 would have it. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress note from 9/5/24 at 9:16 PM by Registered Nurse (RN) N documented R16 was returned from the ER around 5:45 PM. The resident was orientated to room, had no pain, medications were entered and verified by on call Physician Assistant (PA). On 9/18/24 at 10:20 AM, a telephone interview was conducted with RN N who acknowledged R16 was petitioned to the ER for a Behavioral Health consult related to history of suicide attempt and current ideations. When asked if R16 was sent back with an After Visit Summary (AVS) and was there follow-up, RN N did not recall medication changes, and revealed the only follow up was verbally provided by R16 who informed them they were seen by a Doctor in the ER via a ZOOM call and they just sent me back. When questioned if any paperwork from the hospital was sent with R16, RN N replied it would have been placed in a folder at the nurses station and the charge nurses are responsible for picking up the paperwork. On 9/18/24 at approximately 1:00 PM, SW G provided an After Visit Summary (AVS) from R16's petition to the hospital and claimed it was in a pile of paperwork that needed to be scanned into the record. On 9/18/24 at 4:10 PM, an interview and review of the AVS was conducted with SWG and the Director of Nursing (DON). SW G and the DON acknowledged the AVS provided no information of R16's psychological evaluation or medication changes from the hospital. SWG and the DON were informed RN N mentioning R16 told them they were seen by a Doctor via a ZOOM call and they just let her go. SWG replied Oh I did not even know that. SW G was Inquired if any new interventions were placed for R16 since readmission on 9/5/24, and SW G commented 15-minute checks should have been in place. SW G was informed there was nothing documented that R16 had 15-minute safety checks and every observation made today, R16's door was closed. SW G said R16 always wants the door closed and we open it immediately. There was no documentation in progress notes, no updates in the care plan, or from observations regarding interventions. When asked if medical records were requested from the admitting hospital, SWG replied that it is hard to get medical records because you are on hold for so long, leave messages, and they (medical records) never return phone calls. The DON and SW G implied residents are sent out and return frequently with no medical documentation or follow-up. When inquired regarding R16's history of suicide and petitioning to hospital for suicidal ideations, should there have been follow-up and was there an attempt to receive those documents, G replied there was not. The Facilities Social Services Job Description and Essential Functions revealed .Provides direct psychosocial intervention .Perform resident assessments at admission, upon condition change. Creates, reviews and updates care plan and progress notes .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49083 Based on observation, interview, and record review, the facility failed to ensure accurate reconciliation for controlled medications for two residents (R10, R79) of four reviewed for narcotic storage. On 9/18/24 at 5:10 PM, the North Tulip medication cart, was observed with Register Nurse (RN) CC. A record review of the narcotic binder revealed R10 was administered one tablet of Hydrocodone/Acetaminophen 10/325 milligrams (mg) (a narcotic medication) at 2:26 PM by RN CC and five tablets remained. The blister pack was observed having four tablets. RN CC commented that they were pulled into an isolation room to assist another resident and forgot to administer the medication to R10. On 9/18/24 at 5:30 PM, the Back Mum medication cart was reviewed with RN Y. A record review of the narcotic binder revealed R79 was provided one tablet of Tramadol (an opioid pain medication) last given on 9/16/24 at 9:18 PM and 13 tablets remained. The blister pack revealed 12 tablets of Tramadol. RN Y acknowledged that the tablet was administered to R79 prior to dinner and forgot to reconcile the medication in the narcotic binder as administered. On 9/19/24, The Director of Nursing (DON) was informed of the narcotic observations and acknowledged the facility failed to ensure accurate reconciliation.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review the facility failed to ensure a Physician ordered laboratory (lab) diagnostic was completed for one resident (R149) of one residents reviewed for diagnostics. Findings include: On 09/17/24 the medical record for R149 was reviewed and revealed the following: R149 was initially admitted to the facility on [DATE] and had diagnoses including Respiratory failure whether with hypoxia or hypercapnia, Hypoxemia, Pulmonary emphysema and Pulmonary edema. A review of R149's MDS (minimum data set) with an ARD (assessment reference date) of 7/11/24 revealed R149 needed assistance from facility staff with most of their activities of daily living. A Nurse Practitioner (NP) Evaluation dated 7/11/24 revealed the following: Date of Service: 7/11/2024 . General: [AGE] year-old female with chief complaint of shortness of breath. Patient was recently in the hospital for hypercapnia. Patient CO2 (carbon dioxide) was 80. Patient seen and examined today and talked with her husband states that her breathing has become more rapid starting today. Her oxygen level was 94%. She denies any chest pain or tightness .Assessments and Plans .Risk of Complications and/or Morbidity or Mortality of Patient Management: MODERATE .Shortness of breath (SOB): Stat CO2, CBC (complete blood count), CMP (comprehensive metabolic panel) ordered. O2 nasal cannula 2L (liters per minute) If starts to decompensate, will send to ER (emergency room) . A review of R149's Physician ordered laboratory (labs) diagnostics revealed the following order with a start date of 7/11/24 and an end date of 7/11/24: CMP one time only for 1 Day A second Physician's lab order with a start date of 7/11/24 revealed the following: CO2 level STAT for SOB Further review of R149's medical record did not reveal any documentation that R149 had their CO2 level or CMP lab had been drawn and the results reported to the medical provider. On 9/17/24 at approximately 2:25 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the lack of results from the CO2 and CMP and they reported that they would have to look into the concern. On 9/18/24 at approximately 10:27 a.m., during a follow-up conversation with the DON, the DON indicated that orders for the CO2 level and the CMP that had been ordered STAT on 7/11/24 were never completed and they had no results to provide. They indicated they had looked in the laboratory portal and nothing was in it for the requested labs. On 9/18/24 during the exit conference, the Administrator indicated they had identified an issue with laboratory diagnostics and a past non-compliance (PNC) was completed including facility audits and education. On 9/18/24 a review of the PNC that was submitted by the facility for review indicated the facility had determined they were in compliance with laboratory diagnostics being completed on 8/15/24.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review the facility failed to complete a periodic rehabilitation screening and/or evaluation and initiate maintenance interventions upon discharge for a one (R108) of one Resident reviewed for rehabilitation services resulting in the likelihood for further decline in range of motion, impairment with skin integrity, and increase in pain during Activities of Daily Living (ADL). Findings include: Record review revealed R108 was a long -term resident of facility, admitted on [DATE]. R108 had a recent hospitalization and they were readmitted back to the facility on [DATE]. R108's admitting diagnoses included contracture of Right and Left hand, dementia, failure to thrive, depression, and anxiety disorder. R108 was confined to bed and needed extensive staff assistance with their Activities of Daily Living (ADL - mobility in bed, dressing, eating etc.). Based on a Minimum Data Set (MDS) assessment with an assessment reference date of 8/20/24, R108 had a Brief interview for Mental Status (BIMS) score of 00/15, indicative of severe cognitive deficits. However, during an interview completed during multiple observations, R108 was able to answer multiple questions appropriately. An initial observation was completed on 9/16/24 at approximately 10:55 AM. R108 was observed in their bed. R108 was awake and was holding both hands in a closed fist position with tips of their fingers touching the palm of the hands. There was a nightstand on left side of the bed that had a palm protector carrot (a soft pillow shaped like carrot used to prevent worsening of hand contractures and to maintain skin integrity in palm) on top. This surveyor asked R108 about their hands and they reported that the hands had been like this for long time. R108 was questioned if they had used any braces for their hands. R108 reported that their spouse usually visited them later in afternoon around 5 PM and they had been putting the carrot on one hand. R108 reported that staff were not doing it. A follow-up observation was completed later that day at approximately 12:10 PM, 2:15 PM, and around 4 PM. R108 did not have any devices on their hand and the palm carrot was on top of the nightstand in the same area. Both hands were in the clenched position with fingertips in contact the palm of the hands. A follow up observation was completed on at approximately 12:50 PM. R108 remembered the surveyor from the previous day visit stated, I remember you from yesterday. R108's hands were in the same clenched position (with fingertips touching the palm of the hands) and the carrot was observed sitting on the nightstand. A follow up observation was completed later that day at 2:45 PM and on 9/18/24 at approximately 9:45 AM. R108 was in their bed with both hands clenched and no devices. The palm carrot was on top of the nightstand in same spot as the initial observation. Review of R108's Electronic Medical Record (EMR) revealed an order on recent readmission (that read PT, OT and SLP (Physical Therapy, Occupational Therapy and Speech Language Pathology) to evaluate and treat as indicated. R108's care plan revealed that R108 needed staff assistance with eating due to their hand contractures and needed extensive staff assistance due to impaired neurological and musculoskeletal status and they were at risk for impaired skin integrity. R108 also had chronic pain due to bilateral (both) hand contractures. On all the above areas had multiple interventions that included PT/OT/SLP screen/eval/treat as indicated that were initiated on 8/18/23 and 12/28/23. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R108's EMR did not reveal therapy screens/evaluations and or care plans that addressed the above focus areas. Review of R108's Certified Nursing Assistant (CNA) daily task list/Kardex did not reveal that R108 was on any maintenance program to maintain their range of motion, splinting etc. by the CNA's. There was no evidence of any education or follow-up completed by the occupational therapy. A request was made to Therapy Manager (TM) J on 9/18/24 for the OT documents for R108 from 2023 and their routine rehabilitation screenings that were completed till date. Received OT discharge summary dated 8/4/23. OT had goal for R108 to improve their tolerance for brace/palm guard for right hand and the services were discontinued with no maintenance education/program. Under discharge recommendations - restorative program; it read Not indicated at this time. R108 had not received any maintenance program for their contractures from 8/2/23 to current date and there was no evidence of any follow-up from OT. An interview was completed with a CNA C on 9/18/24 at approximately 9:45 AM. They were assigned to work the hall where R108 was residing. During the interview they were queried how did they know what kind of care they needed to provide for a resident. They reported that they would review the Kardex (CNA care plan) for the resident and if they had any specific questions they would ask the nurse. An interview with Restorative Nurse ([NAME]) DD was completed on 9/18/24 at approximately 1:30 PM. They were queried if R108 was on maintenance program and the observation about the palm carrots. They reported that R108 was not on restorative program since 2023 and they did not receive any referral from OT to start any functional maintenance program from August -2023. They added R108 was under functional maintenance program for splints and range of motion until April-2023. [NAME] DD also added that services were initiated based on the functional maintenance program recommendations they had received from skilled therapy services. An interview was completed with TM J on 9/18/24 at approximately 12:30 PM. TM J was queried if R108 was receiving any therapy services. They had checked the therapy EMR and reported that R108 was not receiving any skilled services. This Surveyor asked about the facility process for routine screening and or evaluation of their long-term residents and how skilled rehabilitation clinicians (PT, OT, and SLP) had screened or assessed if there was any change in Resident's condition and initiated interventions timely and if they had a process to measure and complete routine Range of Motion assessment for residents with contractures. TM C reported that they screened residents if they had any falls or based on any referral from nursing team form their interdisciplinary team meetings/risk management meetings. They added that completed screens were on paper forms and they were uploaded into the EMR. There was no evidence of screens on R108's EMR and they reported that they would check. They also reported that they need to reach out to their Regional Director about the routine screening/evaluation and completion of Range of Motion assessment for resident with or at risk for contractures and would get back. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at approximately 10:35 AM, during a follow up interview TM J reported that they did not have a process to routinely screen or assess range of motion for any residents with contractures or residents who were at risk. They reported that R108 was receiving OT services in August 2023 and the services were discontinued as they were signed up for hospice. R108 did not qualify for hospice services and they were discontinued after few months. Surveyor asked why R108 was set up with a functional maintenance plan when OT services were discontinued to prevent worsening of their contractures and why they were not re-screened or evaluated to assess the status of the contractures when hospice services were discontinued, TM J did not provide any further explanation. They added that they understand the concern were discussing with facility administration and their regional manager to come up with a plan. During an interview with Director of Nursing (DON) on 9/19/24 at approximately 11:15 AM they were notified of the concerns regarding not having a periodic screening/assessment for ROM for R108 and the services were discontinued without a functional maintenance program and had not received any service since August-2023. They reported that they were aware of the concern and had discussed with the therapy manager and would working on a process. A facility provided document titled Rehabilitation Therapy and Services with a revision date of 1/1/22 outlined the process for only MEDICARE Residents and did not include all RESIDENTS of the facility. The document did not address all skilled rehabilitation services and addressed only PHYSICAL THERAPY services.

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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** 41415 Based on observations, interviews and record reviews the facility failed to consistently ensure infection control standards, practices and protocols were consistently followed by the facility staff for six (R's 136, 110, 122, 102, 139 & 119) of 28 sampled residents, this deficient practice had the ability to affect all residents residing in the facility at the time of the survey. Findings include: On 9/16/24 at 11:22 AM, Registered Nurse (RN) B and Certified Nursing Assistant (CNA) C was observed exiting the room of R136, with their Personal Protective Equipment (PPE) on that included a gown, gloves, mask & shield. A record review revealed R136 was diagnosed with COVID-19. The signage on R136's door documented the resident was on Droplet/Contact/Airborne precautions. Review of the CDC (Centers for Disease Control and Prevention) protocol documented to discard the gloves and gown before exiting the room and to remove respirator after exiting the room. At the time of the observation the facility's Assistant Director of Nursing (ADON) D was present and witnessed RN B and CNA C to have failed to comply with the standard infection control protocols and practices. ADON D was asked if the observation was the facility's normal protocol and practices and the ADON D replied No, they should have not done that. I will educate them both now. Upon further observation, three of the four Droplet/Contact/Airborne room doors visualized were completely open with full observation of the room and resident visible from the hallway (the rooms observed were for Resident's 136, 110, 122, 102, & 139). [NAME] paper bags were observed on the PPE cart in front of R139's room. RN B was interviewed about the brown paper bags and RN B replied they save their N-95 mask and shield in the bags. RN B was asked if they utilized the same N95 mask and shield for each resident on Droplet/Contact/Airborne precautions, considering there was only one brown bag observed with RN B name. RN B confirmed they change their gown and gloves for every resident on TBP (Transmission Based Precautions), however they utilized the same mask and shield for every resident. RN B stated that's how they were told to do it. RN B confirmed the same mask and shield were utilized for each resident on TBP for the duration of their shift. RN B was observed to reapply their mask and shield and enter into one of the TBP rooms. On 9/17/24 at 3:38 PM, the Infection Preventionist (IP) E was interviewed and informed of the observations and interviews documented above and asked what protocols and practices should be followed by the facility staff. IP E replied the doors should be shut for the Airborne rooms and the staff should be changing their N95's for each resident and wiping down their shield with the purple wipes before going into the resident rooms. IP E stated they will start re-educating now. No further explanation or documentation was provided by the end of the survey. 38271 R119 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/24 at approximately 10:01 a.m., R119 was observed in their wheelchair in the dining room. R119 was observed to have a catheter drainage bag touching the floor on the bottom of their wheelchair. At that time, an observation of R119's room was made and it was not observed to contain any signage indicated facility staff were to use enhanced barrier precautions (EBP) when providing direct care to R119. On 9/16/24 at approximately 10:16 a.m., infection control preventionist E (ICP E) was observed coming down the hallway and putting up EBP signage on R119's bin on door and implementing Personal protective equipment (PPE) bins to their room to don and doff the PPE. On 9/17/24 the medical record for R119 was reviewed and revealed the following: R119 was initially admitted to the facility on [DATE], last readmitted on [DATE] and had diagnoses including Difficulty in walking, Restlessness and Agitation and Chronic obstructive pulmonary disease. A review of R119's MDS (minimum data set) with an ARD (assessment reference date) of 6/9/24 revealed R119 needed assistance from facility staff with most of their activities of daily living. R119's BIMS score (brief interview for mental status) was three, indicating severely impaired cognition. A review of R119's Physician orders for enhanced barrier precautions revealed R119's start date for their EBP was 9/13/24. Approximately dive days after being admitted to the facility. On 9/17/24 at approximately 3:47 p.m., during a conversation with ICP E, ICP E was queried regarding the delay in implementing EBP for R119 and they indicated that they should have EBP Physician orders and signage on the door when they were admitted but they were the only Nurse handling infection control and had a scabies and COVID-19 outbreak so they could not get to some residents who required EBP.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on interview and record review, the facility failed to ensure the pneumonia vaccine was administered after consenting for one (R79) of five sampled residents reviewed for immunizations. Findings include: R79 was admitted to the facility on [DATE] with medical diagnoses that included heart failure, hypertension, diabetes, high cholesterol, and dementia. A Brief Interview of Mental Status (BIMS) score totaled 14/15 indicating R79 was cognitively intact. Record review revealed R79 was offered and signed a consent for the pneumonia vaccine on 6/17/24. Review of the Electronic Medical Record documented R79 refused the pneumonia vaccine. On 9/19/24 at 11:56 AM, an interview was conducted with Infection Preventionist E who confirmed the pneumonia vaccine was documented as refused, and reviewed R79 consented to receive the vaccine. E acknowledged the vaccine has not been administered. On 9/19/24 around 3:00 PM, An interview with Corporate Clinical Services BB acknowledged the facility failed to ensure the pneumonia vaccine was administered after consent.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49083 Based on interview and record review, the facility failed to ensure the COVID-19 vaccine was offered and timely administered after consent for two (R136, R29) of five sampled residents reviewed for immunizations. Findings include: R136 Clinical record review revealed R136 was admitted to the facility on [DATE] with medical diagnoses including cancer, hypertension, blood clots, vascular disease, and renal failure. A Brief Interview of Mental Status (BIMS) score totaled 11/15 indicating R136 had moderate cognitive impairment. On 9/19/24, A clinical record review revealed the SpikeVax Moderna COVID-19 was not offered to R136 until 9/19/24 after a random sample of residents was provided to the Infection Preventionist E. When Infection Preventionist E was questioned why was R136 was just offered today (9/19/24), E responded R136 must of slipped through the cracks.Infrection Preventionist E was inquired of the facility policy regarding offering the vaccine and acknowledged it should have been offered within 72 hours of admission. R29 Clinical record review revealed R29 was admitted to the facility on [DATE] with medical diagnoses including hypertension, diabetes, and pulmonary disease. A BIMS score totaled 6/15 indicating R29 had severe cognitive impairment. On 9/19/24, a clinical record review revealed R29 was offered and consented to receive the SpikeVax Moderna COVID-19 Vaccination on 8/21/24 and was administered the vaccination on 9/19/24. Infection Preventionist E was asked why was the vaccine was not given after consent initially, and Infection Preventionist E replied that some residents required insurance authorization and that can delay administering the vaccine. When ask what the average turn around is for authorization, Infection Preventionist E was unclear and referred to inquire with Business Office AA. On 9/19/24 around 2:00 PM, an interview with Business Office AA confirmed that some residents require insurance authorization prior to administering vaccines and the turn around time does not exceed more than one week. Infection Preventionist E acknowledged the follow up for R29 was missed and not addressed until the survey sample list was reviewed. On 9/19/24 around 3:00 PM, An interview with Corporate Clinical Services BB acknowledged the facility did not ensure the COVID-19 vaccine was offered and timely administered after consent.

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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** 47283 This citation Pertains to intake #: MI00146952 Based on observation and interview, the facility failed to effectively maintain the resident call system that had capability to directly alert the caregivers and or there were no audible or visual alerts systems for care givers which had the potential to affect all 142 residents at the facility. This deficient practice had an increased likelihood for delayed emergency response and/or negative resident outcomes. An initial facility rounds were completed on 9/16/24 at approximately 10:15 AM on the hallway with Rooms 180-195. There was a computer monitor on the hallway mounted on the wall.This Surveyor observed staff members periodically walking to the monitor to check and when the surveyor asked what it was (that they were looking at) staff members reported that was the call light monitor. There was a nursing work area in the adjacent to the opposite hallway. There were no call light (audible or visual) alert systems in the work area and that was later confirmed by the facility staff and leadership. There were no alerts outside resident rooms. Further observation on 9/16/24 and 9/17/24 revealed a monitor (with no alerts) in each hallway, that they were using to check if any call lights were on. During an interview with Licensed Practical Nurse (LPN) Z on 9/17/24 at approximately 2:55 PM they had confirmed that the used the monitor on the hallway to check if any of their Residents needed any assistance and reported that they had worked in a different hall during the morning shift and they were staying over for 4 hours and they were working on this hallway. An interview was completed with Registered Nurse (RN) Y on 9/18/24 at approximately 9:20 AM. RN Y was queried how they had alerted by the Residents if they needed something. RN Y reported that that it come up on the monitor that was mounted on the hall. They were asked how did the staff (nurses and Certified Nursing Assistant/CNAs) knew if they were in the other rooms of not near the monitor and if a resident had an emergency or they needed something and RN Y reported that they had no way of knowing it; the staff had to come and check the monitor to see if a resident needed something. RN Y was queried if they had received any type of alert anywhere else that alerted them that a resident needed assistance and they reported there were no other alerts and confirmed that they had the same system throughout the facility. An interview with CNA C was completed on 9/18/24 at approximately 9:45 AM. They were queried how they were alerted if their residents needed something and they reported that they had to go to the monitor and check if a call light was on. This Surveyor asked CNA C if a resident had a fall or had an emergency and turned on their call light how were they alerted if they were not near the monitor. CNA C reported that they had to check the monitor; had no other way of knowing it and they did not get any other alerts. An interview was completed with CNA K on 9/18/24 at approximately 9:30 AM. Surveyor asked CNA K how id they know if their residents needed any assistance. They reported that they had to walk over to the monitor periodically to check if there were any call lights were on. They had no other way of knowing it and added there used to be pagers for the CNAs and they were not sure what happened to them. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with Director of Nursing (DON) was completed on 9/18/24 at approximately 3:10 PM. The surveyor shared the observations of staff utilizing the monitor to check for call lights, if they were aware of the process and how their staff were responding timely to meet the needs of the residents. The DON reported that they were aware of the call light alert concerns and they had discussed it in the facility leadership meetings. They added they understood the concern and they needed to come up with a plan that would alert their staff. During an interview with the facility Administrator on 9/18/24 at approximately 1:10 PM, this surveyor shared the observations related to the call light system and asked how their staff (CNAs and nurses) received alerts and how they had responded timely to meet the needs of the residents. The Administrator reported the staff prioritized the call lights and addressed the needs accordingly. They were queried how the staff prioritized the call lights when they did not get any direct alerts. The Administrator reported that they went to the monitor and checked the call lights that were on and went to the Resident rooms and then prioritized their tasks. During this interview, the Administrator confirmed the call lights system did not have alerts that alerted the staff. The Administrator was notified of the concerns with their call light system. E-mail requests (two) were sent to facility administrator on 9/18/24 and 9/19/24 to provide the facility policy on monitoring their call light functioning and the manufacturer's operation manual for their current call light system. Requested information was not received prior to the survey exit. 38271 R17 On 09/16/24 at approximately 10:54 a.m., R17 was observed in their room, up in their bed. R17 was queried if their call light (a button used to request facility assistance) was being answered in a timely manner and they indicated it did not work. At that time, R17's call light was tested and the light above their door did not light up indicating R17 needed assistance but the monitor close to their room indicated R17 had pressed their call light and required assistance. On 9/16/24 at approximately 10:57 a.m., Certified Nursing Assistant I (CNA I) was queried how they knew R17 needed assistance and they reported that they have to look at the monitor to see what call lights are on. CNA I was queried if that was the way the system worked and they indicated that there was also a pager notification of call lights going on, but that nobody carries their pagers because half of them are lost and not returned. CNA I stated that they do no use their pager and did not have it on their person. 34275 On 9/17/24 at approximately 1:00 PM a resident council meeting was conducted with five residents who asked to remain anonymous. When asked about care provided in the facility the residents reported that on several occasions, they will push their call lights and wait a long time for staff to respond. One resident noted that they have waited over two hours for assistance. Another resident reported that the staff do not carry pagers and the only way they know that a call light goes off is if they see it on only one monitor. Another resident reported that the concern had been brought up on several occasions during resident council meetings. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility resident council notes from 4/24 to 9/24 was conducted. The documentation noted concerns regarding call- light response time. Notes on 5/23/24, 6/24/24, 7/24/24, 8/8/24 and 9/5/24 all contained notes regarding call light response time and/or working call lights. On 9/18/24 at approximately 2:02 PM, an interview was conducted with Activity Assistant (AA) F. AA F reported working at the facility for over [AGE] years. When asked about the resident council meetings and concerns regarding call light response, AA F confirmed frequent concerns had been noted about call light response time. AA F noted that the concerns are brought up to other staff members and they continue to address the issues. On 9/19/24 at approximately 10:01 AM, an interview was conducted with the Administrator regarding call light response. The Administrator reported they were aware of concerns regarding the call light system. They noted the only way staff became aware that a resident has pushed their call light is by checking the monitor at one central location. The Administrator noted that staff do not carry pagers, nor can they be alerted by an overhead light.