STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235343	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kith Haven	G 1069 Ballenger Hwy Flint, MI 48504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00149049. Based on observation, interview and record review, the facility failed to ensure that residents' rights/dignity was maintained for Resident #'s 6, 38, 60, 81, 82, 94, 97 and 127, of a sample of 26 reviewed for residents' rights, dignity and ADL (activities of daily living) care, and two residents in room [ROOM NUMBER], resulting in long call light wait times, Resident complaints of food served at an unpalatable temperature, menu not followed, lack of assistance with dressing, lack of ADL care, long and jagged fingernails, complaints of staff rudeness with Resident interaction and the potential of unmet care needs, weight loss and dissatisfaction with care, services and meals. Findings include: Resident #6: A review of Resident #6's medical record revealed an admission into the facility on [DATE] and recent admission on 1/3/24 with diagnoses that included end stage renal disease, dependence on renal dialysis, acquired absence of right leg below knee, and anxiety disorder. A review of the Minimum Data Set assessment revealed intact cognition, and the resident was independent for most activities of daily living but needed setup or clean-up assistance for bathing. On 1/29/25 at 10:20 AM, an observation was made of Resident #6 seated in a wheelchair, in the hallway, with a towel over top his lap, and his legs were bare. The towel was small and did not cover the resident past mid-thigh. The Resident was asked questions, responded with answers and engaged in conversation. The Resident was upset and indicated he could not find any sweatpants. When asked if he had let staff know, the Resident reported he had told the nurse earlier today and reported they were going to call down to laundry and get them but has not gotten any yet. The Resident is holding a tee shirt and a blue sweatshirt and reported he got them for his birthday and now the pants were missing as well as his orange pants and another pair of pants. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 10:35 AM, an observation was made of Resident #6 seated in a wheelchair with a towel over his lap and legs bare in the hallway. The Resident remains upset over his clothing missing and Certified Nursing Assistant (CNA) R came down the hall and told the Resident that laundry was called but there was no answer. The Resident was upset and told the CNA he had no pants and that he was also missing other pants and expressed frustration. The CNA left the Resident in the hall with a towel across his bare legs. On 1/29/25 at 10:45 AM, an interview was conducted with Resident #6 in his room. The Resident answered questions and engaged in conversation but was not always understandable in some of his explanations. The Resident indicated the facility does his laundry and he got his sweatshirt back but did not get his sweatpants back that match. The Resident indicated that he was missing three pairs of pants. The Resident had boxes of personal belongings stacked on the floor across from his bed. When asked if staff came to look for other clothes, the Resident indicated they had not, and he wanted his ones back that matched his sweatshirt. The Resident was in his room at this time and continued to have a hand towel over his lap and his legs were bare. Resident #38, Resident 81: On 1/29/25 at 11:28 AM, an interview was conducted with Residents #38 and #81 who shared a room together. The Residents were interviewed, answered questions and engaged in conversation. The Residents were asked if there were any issues with care. Both Residents voiced complaints of food being cold when received in the room. The Residents reported they liked to eat in their room, and it will often be cold. Resident #81 expressed that it did not matter which meal because they would come cold for all three meals. Resident #81 reported that the trays will come up and sit in the hall, and pointed outside the door, indicated sometimes seeing or hearing the cart but will not get their tray for a while after. Resident #81 reported breakfast was at 8:00 in the morning but they don't get it sometimes until 9:00 or 9:30 am. Resident #38 reported, when it's like that, I just leave it. When asked when the food was not warm, she did not eat it, the Resident stated, I can't eat it like that. Resident #60: A review of Resident #60's MDS revealed intact cognition, and the Resident needed substantial/maximal assistance with shower/bathe, upper body dressing, lower body dressing and needed partial/moderate assistance with personal hygiene. On 1/29/25 at 11:05 AM, an interview was conducted with Resident #60 who was in bed with the head of the bed elevated. The Resident answered questions and engaged in conversation. The Resident was observed to have very long fingernails. The Resident stated, They are too long, and indicated that his daughter was coming and will take care of them. When asked if staff offered to trim his nails, the Resident stated, They are too busy to do them. When asked if they offered with his shower, the Resident indicated he had a shower yesterday and stated, They didn't get done, they are starting to curl, and showed the edges of the nails are starting to curl under. The Resident reported I scratch myself; they are too long right now. Resident #82: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 10:03 AM, an interview was conducted with Resident #82. The Resident was asked questions and engaged in conversation. The Resident had been in the bathroom, came out and had her breakfast tray on her bedside table. When asked if the food was still warm, the Resident reported that it was cold. The breakfast consisted of scrambled eggs, toast that was well done and very dark, and oatmeal. The Resident reported there was no jelly, no butter and the toast was burnt and stated, I can't eat that. The Resident reported not wanting the oatmeal either with no sugar to go on it. There was no sugar on the tray, no jelly and the toast did not look like it had been buttered. During the interview, staff came by and handed out a menu. The staff did not check on the Resident's breakfast tray, offered to warm the tray or removed the tray. The Resident looked at the menu and reported they were to have biscuits and gravy and scrambled eggs. The Resident did not receive the biscuits and gravy. Resident #97: A review of Resident #97's medical record revealed an admission into the facility on [DATE] with diagnoses that included anxiety disorder, depression, lymphedema, and open wound of lower leg. A review of the MDS revealed the Resident had intact cognition and needed substantial/maximal assistance with shower/bathing, partial/moderate assistance with personal hygiene and transfers. On 1/30/25 at 9:32 AM, an interview was conducted with Resident #97 who was lying in bed with the head of the bed elevated. The Resident answered questions and engaged in conversation. The Resident was asked about bathing and the Resident reported she liked to shower and that her days to shower were on Tuesday and Friday. The Resident reported that the staff don't always offer a shower, that she must remind them and had recently missed a shower that was not offered at another time having to wait for the next shower day. The Resident reported that staff can be rude or have an attitude towards her or disrespectful. The Resident had reported they had long call light wait times and had incontinence when waited for assistance with the call light on. The Resident reported problems with cold food and stated, 50:50 chance the meal is cold. The Resident reported that the menu was not always followed, the alternative was not always available if it was not ordered ahead of time, but the menus are passed out late and you don't know what you are going to get, so how would you know to order something else. The Resident reported not getting a menu today to know what was on the menu for breakfast. Resident #38, Resident 81: On 1/29/25 at 11:28 AM, an interview was conducted with Residents #38 and #81 who shared a room together. The Residents were interviewed, answered questions and engaged in conversation. The Residents were asked if there were any issues with care. Both Residents voiced complaints of food being cold when received in the room. The Residents reported they liked to eat in their room, and it will often be cold. Resident #81 expressed that it did not matter which meal because they would come cold for all three meals. Resident #81 reported that the trays will come up and sit in the hall, and pointed outside the door, indicated sometimes seeing or hearing the cart but will not get their tray for a while after. Resident #81 reported breakfast was at 8:00 in the morning but they don't get it sometimes until 9:00 or 9:30 am. Resident #38 reported, when it's like that, I just leave it. When asked when the food was not warm, she did not eat it, the Resident stated, I can't eat it like that. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 2:40 PM, an interview was conducted with Dietary Manager H regarding complaints of food not at a palatable temperature for residents. When asked about complaints, the DM indicated they have had some complaints regarding cold food. When asked if they had done any audits, she reported she had not done a test tray, but the Dietician had. An observation of breakfast passed in the 300 hall area at 9:22 AM this morning was reviewed. The DM reported breakfast started to be served about 8 AM in the dining room, then room trays were assembled after that and that the trays were passed depending on when the aides were available. The DM indicated that breakfast was a slower meal with them (residents) just getting up, and reported that they were working on getting the trays out earlier. On 1/31/25 at 11:15 AM, an interview was conducted with the Director of Nursing (DON) with a review of multiple concerns. Resident #97's shower/bathing was reviewed with a shower documented as given on 1/7/25 and then 10 days later on 1/17/25. There was no documentation that the Resident had refused. The DON indicated that had staff documented that the Resident refused, they would have gotten an alert and it would have been addressed by finding out issue and reschedule the shower. The DON reported because it had not been charted at all, that they did not get the alert. The DON reported that a grievance form had been filled out with all the Resident's concerns and the concerns were addressed. The grievance/complaint form had been requested earlier in the survey and was not received by the facility. The DON was asked for the form and the DON reported that they should have a copy. The DON was asked about nail care and reported that the nails were offered during bathing and as needed. The DON was informed of the Resident complaints of cold food. The DON reported that they serve in the dining room first then put the trays together, put on the tray cart and they go to the hall for the Residents that eat in their room. On 1/31/25 at 1:48 PM, an interview was conducted with the Assistant Administrator (AA) Q regarding complaints voiced by Resident #97. The AA indicated that the Resident had voiced concerns, and they had filled out a concern form and had provided follow through with the concerns. The facility Grievance form for Resident #97 was not received prior to the exit of the survey. Residents in room [ROOM NUMBER]: On 1/29/25 at 1:07 PM, an observation was conducted with Resident in room [ROOM NUMBER]-1 of long fingernails with debris underneath the fingernails. The Resident was asked when their last shower was, but they reported they were unsure. When asked if staff had offered to trim their fingernails, the Resident indicated staff had not offered and they would not refuse. The Resident in 328-3 reported having a recent shower but had not been offered nail care. An observation was made of the Resident nails being long and jagged. A review of facility policy titled, Resident Rights, effective 5/14/24, revealed, Policy: The facility protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . 22927 Hydration/Water Pass: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 01/30/25 at 08:19 AM with the Director of Nursing (DON) of Resident #41 revealed the call light on the floor. The surveyor had the DON go into the resident room and give it to the resident, there is no clip to his call light. Resident #41 was lying in bed and stated that he still had Third shift water dated 1/29/2025 with no ice, and why was there no fresh water that morning. Resident #41 stated that the staff are lazy, they are good when they work, but they don't want to work. They talk to us like we live on the street, there's no respect, very rude to the way they talk to us. The DON stated that there was No clip on the call light, they break, and we have replaced them. Fresh Water passes are done at the end of each shift, night shift should have passed the fresh water for this morning before 7:30 am at the end of their shift. Observations and interview on 01/30/25 at 08:30 AM the Surveyor reviewed resident rooms 304, 303, 302, 301, for fresh waters, all were dated 1/29/25 3rd. room [ROOM NUMBER]-2 water was dated 1/27/2025. room [ROOM NUMBER]-1 dated 1/29/25 3rd, 305-2 undated, 306-2 water dated 1/29/2025 3rd, 311-1,2,3,4 all had water not dated and with no ice. The Resident in bed 311-4 stated that's last night's water when asked why his roommate had no ice in his water. Observation on 01/30/25 at 08:36 AM of Resident #102 in room [ROOM NUMBER]-2 noted that the call light was on the floor, and white Styrofoam glass with water dated 1/29 3rd. In an interview on 01/30/25 at 02:42 PM with the Certified Dietary Manager (CDM) H stated that the aides pass the water at the end of their shift, 3 times a day. Record review of the facility 'Oral Hydration' policy dated 12/10/2024 revealed it is the policy of the facility to assist residents to maintain adequate hydration whenever possible Procedure: (5.) Each resident will be provided bedside water unless contraindicated . Dining Observation: Observation and interview on 01/30/25 at 08:45 AM on the 3 North unit of resident rooms when checking for [NAME] pass, revealed that the residents complained of no breakfast yet this morning. Multiple rooms reviewed for water pass with no breakfast trays noted at 8:45 AM. Observed the 3 North dining with steam table set up in progress while waiting for the elevator. During the ride in the elevator down, The Certified Dietary Manager (CDM) H got on the elevator at the second floor, and was asked what time breakfast was served? she stated 8:00 AM. Observation on 01/31/25 at 08:42 AM on the 3 North unit revealed the First breakfast tray to the hallway from the dining room, by Certified Nurse assistant (CNA) I took the meal tray to room [ROOM NUMBER]-2. Dignity: Resident #94: In an interview on 01/29/25 at 01:08 PM with Resident #94 revealed that the facility staff on the 3 south unit are rude and disrespectful. If Resident #94 goes over to the 3rd floor south unit side of the building the staff tell the resident to get out of there and are nasty to the resident. Resident #127: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/29/25 at 09:42 AM with Resident #127 during the initiate screening task of the survey revealed the resident had concerns stating: 'they are so disrespectful, they yell at us residents, they don't care about us, they will ignore the residents and stand around and talk. Call lights take over 15 minutes to get answered. Here's an example, last night I took a nap, and I woke up to a chemical smell in my room, and asked the staff if they could smell it, they said no, and walked out. They just walk away and don't address the issues. Record review of the facility 'Certified Nursing Assistant' job description undated, revealed the position requires patience, compassion and a desire to care for the residents in a gentle and empathetic manner. essential functions included: record fluid intake and output, assist with eating and hydration, make routine rounds on each assigned resident every two hours, provides and reinforces other behavior consistent with the resident's dignity. Resident Rights: Promotes and protects resident's rights; treats residents with dignity and respect .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00149049. Based on observation, interview, and record review the facility failed to provide a clean, comfortable and home like environment to ensure that resident rooms were clean, uncluttered, and in good repair for 3 Resident's #30, #39, #115 including two resident rooms (103 and 119) , resulting in an unclean physical environment. FACILITY Environment: On 1/29/2025 at 10:48 AM, room [ROOM NUMBER]'s bathroom was observed to be very soiled. The white toilet seat had many smears of brown dirt on it and the floor was covered in discolored brown stains near the toilet. Resident #39 was asked if he used his bathroom and he said he did; he said he tried to provide his own care, as much as he could. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #39 was admitted to the facility on [DATE] with a tracheostomy, a feeding tube, heart disease, COPD, anxiety, depression, GERD, arthritis and venous insufficiency. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident was independent with care. On 1/29/2025 11:42 AM, room [ROOM NUMBER] was observed to be very cluttered on the side near the window. There were many items, including bags, and boxes on the floor, mainly on the bedside near the window. There was no clear path on that side of the bed. Resident #115 was observed lying in bed. He did not want to answer questions. A record review of the Face sheet and MDS assessment indicated Resident #115 was admitted to the facility on [DATE] with diagnoses: Heart failure, cirrhosis of Liver, depression, malnutrition, hypothyroidism and lymphedema. The MDS assessment dated [DATE] with full cognitive abilities with a BIMS score of 14/15 and the resident needed some assistance with care. A review of the Care Plans for Resident #115 identified the following: (Resident #115) is at risk for fall related injury and falls (related to): diuretic medications, history of falls . date created 5/15/2024 and revised 8/14/2024 with Interventions: Keep the resident's environment as safe as possible with : even floors free from spills and /or clutter . date initiated 5/15/2024. On 1/31/2025 at 2:10 PM, the Environmental Services Manager J was interviewed about the soiled and cluttered rooms, he said he was new at the facility and would look into it. 38471 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30: During initial tour on 1/29/25, Resident #30 was observed enjoying his lunch at bedside. The resident provided permission to enter his bathroom and on the floor in front of the toilet was a soiled brief with what appeared to be feces inside of the it. On the back of the toilet seat bowl was a clump of dark brown substance adhered to the toilet bowl. On 1/30/2025 at 9:05 AM, Resident #30 was observed resting in bed. His bathroom was observed again and the clump of brown, adhered substances was still on the back of the toilet seat bowl. 37771 Resident #81: On 1/29/25 at 11:28 AM, an interview was conducted with Resident #81 who was in bed in their room. The Resident complained that the sink in the room would overflow and that it did not drain well. The Resident reported that their roommate would use the sink, or staff would put towels in the sink to get them wet, run the water to get it warm enough and then the sink would overflow. An observation was made of the sink turned to flowing and the sink basin filled with the water not going down timely before the water started to get warm. The Resident stated, before it gets warm, the sink is overflowing. Resident #97: A review of Resident #97's medical record revealed an admission into the facility on [DATE] with diagnoses that included anxiety disorder, depression, lymphedema, and open wound of lower leg. A review of the MDS revealed the Resident had intact cognition and needed substantial/maximal assistance with shower/bathing, partial/moderate assistance with personal hygiene and transfers. On 1/29/25 at 12:55 PM, an observation was made of Resident #97 sleeping in bed. The Resident did not arouse when their name was spoken. An observation was made of clutter in and around the Resident's bed area. There was a bag of pop cans positioned on the floor that was filled and overflowing. The top opening of the bag was not secured. Another bag was next to it that had a couple cans in the bag. An observation was made of multiple pop bottles under the Resident's bed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to review and revise care plans for 2 Residents (#39, #64) of 3 residents reviewed, including Resident #39 with a swallowing deficit, and Resident #64 who had weight loss and a change in condition, resulting in the likelihood for missed interventions in treatment and unmet needs. Finding include: Record review of the facility 'Care Planning' policy dated 6/24/2021 revealed every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs identified in the comprehensive assessments and prepared by an interdisciplinary team who includes but not limited to; attending physician, a registered nurse who is responsible for the resident, a nurse aide, a member of food/nutrition services, the resident or resident representative, therapy staff as required and other an ancillary staff. (9.) The care plan and resident Kardex will be updated on admission, quarterly, annually and with significant changes. This includes adding new focuses, goals, and interventions and resolving ones that are no longer applicable as needed. Record review of the facility 'Standards of Nursing Practice' dated 4/11/2023 revealed the delivery of nursing care in the facility is based on a thorough evaluation of the resident to identify his or her needs. Once the resident needs are identified, a comprehensive care plan is developed to attain individualized resident goals. the care plan is implemented by the interdisciplinary team and is continually evaluated for effectiveness. the care plan is updated as necessary to meet the resident's needs. Resident #64: Observation on 01/29/25 at 9:50 AM of Resident #64 was lying in bed with breakfast meal tray on bedside table, no bites noted out of meal/foods, orange juice, milk, cereal soggy appearing. In an interview on 01/29/25 at 11:29 AM, Resident #64 stated that he had lost weight. Observed a carton of health shake on the over bed table. Resident #64 stated that his Hands are shaky and has hard time drinking the shake. Observation on 01/30/25 at 08:14 AM, Resident #64 was noted to be lying in bed with No breakfast tray in room yet. Resident #64 stated that he eats his meals in bed. Observation on 01/30/25 at 9:20 AM, Resident #64 was lying in bed with breakfast meal tray in front of resident no attempt to feed self. Resident #64 stated that his hands shake when he's eating, and no one helps him with meals. Record review of Resident #64's weight log revealed on 12/11/2024 weight 156.1 and on 1/13/2025 weight 147.5 equal a loss of 5.7% weight in 33 days. (continued on next page)

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

An interview and record review on 01/30/25 at 03:01 PM with Registered Dietitian (RD) F revealed Nutritional evals are quarterly every 3 months and a full nutritional assessment annually. RD F was asked about Resident #64' weight loss was recently identified at 5.6% loss his weight decrease could be affected by diuretic and anti-psych meds. Record review of Resident #64's nutritional care plan for interventions: new order for med pass twice daily started on 1/14/2025, and health shake daily started 2/21/2024. Begin weights weekly after the significant weigh. change, and prior in December 2024 was monthly. Record review of the nutritional care plan Interventions should have been added med pass and Health shakes 1220 cal and 46-gram protein daily. Assist the dining is nursing service to feed the resident intake is done by CNA's. RD F stated that Monitoring intake is done by the RD, the Resident #64 eats 0% to 25% according to his intake record. RD F stated that he did trigger Resident #64 for a significant change due to weight loss today (1/30/2025).

In an interview and record review on 01/31/25 at 12:02 PM with the Registered Dietitian (RD) F record review of Resident #64's nutritional care plan noted nutritional supplement intervention on 2/20/2024, and that there were no other added interventions noted on the care plan related to the recent significant change of weight loss of 5.6% in a month. RD F reviewed the physician's orders of 1/14/2025 of Med Pass ordered by the other RD G. Record review of the nutritional care plan revealed the order for Med Pass was not placed on the care plan. Resident #64 has a Stage 4 pressure ulcer to right heel and an unstageable black eschar pressure ulcer to medial outer foot. RD F was not aware of pressure ulcers for Resident #64. Record review of Resident #64's protein intake currently is at 46 grams which is only 58% of his daily protein requirements, which is inadequate to promote healing of pressure wounds. RD F stated that Resident #64's protein needs should be 80 grams daily. Record review of documented intake is less than 75%-0% per meals. Significant change in weight loss of 5.6%. RD F will plan to re-weight Resident #64 and the if he gains weight will add med pass to 3x daily, if the resident does not gain weight, will add protein supplement Pro-stat 1x daily (Pro-stat 19 gram/ml, needs 65 grams).

37666

Resident #39:

A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #39 was admitted to the facility on [DATE] with a tracheostomy, a feeding tube, history of removal of his larynx, difficulty swallowing, heart disease, COPD, anxiety, depression, GERD, arthritis and venous insufficiency. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident was independent with care.

On 1/29/2025 at 10:50 AM, Resident #39 was observed awake, lying in bed in his room. He whispered he had a feeding tube, and a tracheostomy. He pointed at both. The feeding tube site was dry; he said had the feeding tube for about 3 years. He said he was to receive his enteral/tube feeding 5 times a day.

A record review of the January 2025 Medication Administration Record/MAR and Treatment Administration Record/TAR for Resident #39 indicated the resident received very little of the enteral nutrition. He refused it daily and would have a can one day and go several days with none. He also refused the extra water provided via the feeding tube ordered 3 times a day. He accepted water with his medication, but often refused that too.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kith Haven		STREET ADDRESS, CITY, STATE, ZIP CODE G 1069 Ballenger Hwy Flint, MI 48504	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/2025 at 3:13 PM, Registered Dietitian/RD F and RD G were interviewed about Resident #39. RD F said the resident weighed 139 lbs. on 1/24/2025. This was comparable to what he had weighed recently. He said the resident did not have an order to eat food, but he had an order for ice chips. He said the resident did not have a continuous tube feeding but was to receive 1 can of enteral/liquid nutrition via the feeding tube 5 times a day. He said this was because the resident liked to be mobile in his wheelchair in the building. The RD was asked how Resident #39 could receive almost none of the tube feeding or fluids and not lose weight or be dehydrated. From January 1st, 2025- January 30th, 2025, the resident had accepted 27 cans of tube feeding; there was a possible 148 cans for the month. The Dietitians said the resident left the building daily and he had been observed eating food orally/via mouth. A review of the Care Plans for Resident #39 identified the following: (Resident #39) has potential for Dehydration and fluid deficit related to: PEG/feeding tube present, often refuses tube feeding, date initiated 2/28/2024 and revised 12/17/2024 with Interventions that were all dated 2/28/2024. There was no mention of the resident also refusing the extra water flushes. It did not mention he received cups of ice chips. (Resident #39) requires Speech Therapy related to decline in function or to maintain/slow decline secondary to . decline in swallowing of liquids, Decline in swallowing of solids, date initiated and revised 11/14/2024 with interventions all dated 11/14/2024. On 1/31/2025 at 11:51 AM, RD F was interviewed about Resident #39. He said the resident was scheduled for a swallow evaluation on 2/13/2025 and it was ordered on 1/28/2025. Reviewed this was not mentioned on the Care Plan. Reviewed with RD F the resident's Care Plan said he required Speech Therapy but it did not say he was not receiving it. RD F said the resident was not currently receiving Speech Therapy. He also said there were progress notes indicating Resident #39 had been observed eating food, including a hamburger. The RD F said a Speech Therapist had seen the resident on 1/15/2025 and was awaiting the swallow evaluation to determine what services the resident might need as he continued to refuse enteral nutrition/tube feeding. On 1/31/2025 at 1:53 PM, Resident #39 was interviewed. He was sitting in the dayroom in his wheelchair, smiling. He was asked about refusing his enteral nutrition and said he took it sometimes and waved his hand and shook his head no. When asked if he was eating something else, he shook his head yes. When asked what he was eating, he said everything and threw his arms wide.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to 1. Ensure care was provided for a resident with a Life Vest Resident #115, and 2. Ensure wound care was ordered and completed timely for Resident #383 of two residents reviewed for standards of practice. Findings Include: Resident #383: 01/30/25 around 12:15 PM, Resident #383 was observed in the dining area with other residents enjoying his lunch. A bandage was observed spanding the length of his left forearm that was dated 1/27- at 2130 with the initials SS. When the resident was queried on what happened to his arm, he stated it occurred while he was jumping a fence. Review was completed of this TAR (Treatment Administration Record) and there were no current orders specifically for his left arm. The order that was initiated for his left rear forearm was discontinued on 1/27/2025. Furthermore, there was no wound care treatment documented on TAR as completed for this resident on 1/27/2025. On 1/30/2025 at approximately 1:00 PM, Nurse N was asked if she could locate the wound care order for Resident #383's left forearm. She was not able to locate an order in the chart for this treatment. On 1/30/2025 at approximately 1:30 PM, the DON (Director of Nursing) observed the Resident #383's dressing. The dressing was loose and not covering the injuries that were visible with date of 1/27. The DON reported she was unsure as to why there was not an appropriate order for the dressing or why it had not been changed in two days. Review was conducted of Resident #383's medical record and it indicated he admitted to the facility on [DATE] with diagnoses that included, Chronic Respiratory Failure, Alcohol dependency, Depression, Anxiety and Hypertension. 37666 Resident #115: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #115 was admitted to the facility on [DATE] with diagnoses: Liver cirrhosis, heart failure, pulmonary hypertension, lymphedema, hypothyroidism, and depression. The Minimum Data Set/MDS assessment dated [DATE] revealed the resident had a full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 14/15 and performed most care per self. On 1/30/2025 at 11:42 AM, Resident #115 was observed curled up in bed, covered with a blanket, awake. He answered a few questions then said that was enough; he did not want to talk anymore. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician orders for Resident #115 identified an order Patient is to wear Life Vest at all times. Ensure spare battery is charged at all times, dated 8/15/2024. There was no further information or instructions. Per the Cleveland Clinic, dated reviewed on 5/19/2022, A LifeVest is a wearable defibrillator that can stop an abnormal heart rhythm without anyone's help. People at risk of sudden cardiac arrest wear it while waiting for a more permanent solution . It monitors your heart all the time. If a life-threatening arrhythmia starts, your LifeVest delivers a shock treatment to restore your heart to a normal rhythm . If you have ventricular tachycardia (rapid heartbeat) or ventricular fibrillation (rapid, uncontrolled, ineffective heartbeat), the device sounds an alarm to verify that you're not responsive. If you are conscious, you have less than one minute to respond to the alarms by pressing two buttons to stop the treatment. If you don't respond to the alarms, the device warns bystanders that you're about to receive a shock . You can get up to five treatment shocks . Risks or disadvantages of a cardiac LifeVest include: It doesn't work if you don't wear it; You need to be ready to respond to alarms at any time; You can't wear it while bathing; You need to change the battery every day; People near you risk injuring themselves if they touch you while you're receiving a shock . A record review of the progress notes identified the following: 1/27/2025 at 6:31 AM, a nurses note,Patient has life vest on but vest is not connected to battery. Writer asked resident if (he) could plug it in and resident stated No. Battery is on charger and vest is not plugged into monitor. Patient was educated on importance of the vest being plugged into the monitor for its effectiveness. Patient would not allow monitor to be plugged in. There was no documentation this was reported to the Physician or Nurse Practitioner. The next documentation for Resident #115 was on 1/29/2025: 1/29/2025 at 1:25 AM, a nurses SBAR summary for the Provider related to the resident falling. There was no mention of the Life Vest. 1/29/2025 at 3:03 AM, a nurses note, Resident had an unwitnessed fall. He was observed sitting on buttocks leaned against bed. Vitals 97.0, 75, 16, 83/46(blood pressure- very low). Resident appeared to be drunk. Bottle of liquor found on bedside table . There was no mention if the resident was wearing the Life Vest or if it was connected to the battery. A review of the Vital signs for Resident #115 revealed the resident often had very low blood pressure. 1/30/2025 untimed, a provider note related to the resident's fall did not mention the Life Vest. A review of the Care Plans for Resident #115 identified the following: (Resident #115) is at risk for cardiac complications related to multiple cardiovascular diseases: Edema, CHF, Pulmonary hypertension, oxygen usage, life vest, EF (ejection fraction) 20-25%, Date initiated 5/15/2024 and revised 1/29/2025. There were no interventions for the Life Vest to ensure it was worn correctly, monitoring or instructions for use and staff were aware of their responsibilities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Kardex (a document to guide care for the resident) revealed there was no mention of the resident wearing a Life Vest. There was one intervention that stated, Assist with charging batteries as needed. But it did not say what the batteries were for. A review of the Tasks documentation indicated there was no mention of the Life Vest. During an interview with the Director of Nursing on 1/31/2025 at 9:15 AM, indicated there was no education for staff for the Life Vest. A review of the facility policy titled, Wearable cardioverter-defibrillator use, dated revised August 19, 2024, provided, A wearable cardioverter-defibrillator (WCD), also know as a defibrillator life vest, is a device that a patient can wear under the clothing that delivers a shock to the heart when it detects ventricular tachycardia or ventricular fibrillation. It's a temporary therapy for patients at high risk for sudden cardiac death . The therapy isn't recommended for patients who: . are unwilling to wear the vest as necessary . If you're with the patient when the WCD alarms and sends out a voice alert, don't press the response button because the button was designed for patient use to assess the patient's ability to respond . Documentation: Documentation associated with WCD use includes: that the patient is wearing the WCD, tolerance of the WCD, ability to respond to the WCD alerts, defibrillation attempts made by the WCD . complications . practitioner notification . teaching .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to prevent a facility-acquired pressure ulcer/skin injury for one resident (Resident #64) of 5 residents reviewed for pressure/skin issues, resulting in Resident #64 developing two new facility-acquired pressure ulcers/skin injuries as a result of poor nutritional intake including a low protein diet and and also resulting in weight loss while residing in the facility. Findings include: Record review of facility 'Skin Management' policy, dated 9/19/2024, revealed it is the policy of the facility should identify and implement interventions to prevent development of pressure ulcers. Practice guidelines: (10.) A nutritional evaluation: a registered Dietitian will evaluate all residents identified with skin impairment for nutritional status in a timely manner. Review laboratory results pertinent to wound healing. (12.) If a new area of skin impairment is identified, notify the resident . Resident #64: In an interview on 01/29/25 at 11:24 AM, Resident #64 stated that he had sores on his right foot that hurt and were painful. He does not know how he got them. Observation of the left leg was an amputation. Observation on 01/29/25 at 11:25 AM with Certified Nurse Assistant D revealed the right foot heel with bandage in place with drainage coming through the dressing dated 1/28/2025. There was drainage noted on the bedding/sheet of dried dark ring with smears where the foot had been swiped across the sheet. Record review of Resident #64's Minimum Data Set (MDS), dated [DATE], quarterly revealed an elderly resident with Brief Interview of Mental status (BIMS) score of 9 out of 15, impaired cognitive ability. Section GG Functional abilities: Coded 01. Dependent- Helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting, shower/bathe, upper/lower body dressing, putting on/off footwear, personal hygiene. Code 05. Set-up/clean-up assistance the helper sets up or cleans up, resident completes activity for eating and oral hygiene. Section M Skin conditions: Assessed Resident #64 at risk of developing pressure ulcers/injuries and had no unhealed pressure ulcers/injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview was conducted on 01/30/25 at 12:42 PM with Wound Care Nurse Practitioner E and Licensed Practical Nurse (LPN) Wound Care D of Resident #64's right foot wounds. Nurse Practitioner E removed the old dressing revealed a right upper medial black (eschar) area below the back side of the smaller toes. Nurse Practitioner (NP) E palpated the blacked area, and the skin area was soft had a mushy texture per NP. Observation of the right heel area revealed a large open area with bone/tendons noted in the wound (Stage IV). Wound 1.) Odor and serosanguinous drainage of heel was noted. Heel area was cleansed with wound cleaner, dressing applied. Wound 2.) Right medial foot one up under toes, and wound cleanser applied, Medi-honey treatment applied, eschar to the upper toe area. Wound care Nurse Practitioner (NP) E stated that the Medial lateral upper foot had eschar, and the Medi-honey treatment will break down the bad tissue, and that an X-ray of the foot would be ordered. Both pressure ulcer/skin injuries were cleansed and ABD pad and wrapped with krilex gauze. In an interview on 01/30/25 at 12:51 PM, Licensed Practical Nurse (LPN) D wound care nurse revealed that Resident #64 kicks with that leg, has poor nutrition, and poor circulation, and resident will rest his foot on the foot board and kick off his soft boot. Record review of Resident #64's care plan, pages 1- 101, revealed Impaired skin integrity/pressure injury related to weakness, stroke with impairments, dementia. initiated on 2/14/2024 had interventions of: Encourage offloading pressure to right heel with pillows or heel boot as tolerated by resident, created 1/30/2025. Provide diet as ordered, observe and document food acceptance and offer substitutes as needed. Record review of Resident #64's progress notes, dated 12/24/2024, revealed total body skin assessment: skin turgor: good elasticity. Skin color: Normal for ethic group. Temperature of skin: Warm (normal). Skin Moisture: Normal. Skin condition: Normal. Number of new skin conditions: zero. Record review of Resident #64's progress encounter notes telehealth, dated 12/31/2024, revealed nurse reports right heel cleansed with wound clean skin prep and dressed with a 4 x 4 dressing and reported wound care. Due to boggy right heel and hard wound forming in the middle of the bogginess. Record review of Resident #64's Interact SBAR summary, dated 12/31/2024, revealed a change of condition-nursing observation of boggy right heel with harden broken down area. record review of Resident #64's progress note, dated 1/2/2025, revealed elderly resident seen today for assessment to acute pressure ulcer to right heel. He is lying in bed during examination, calm, and cooperative, orientation at baseline. On examination, an approximately 1.4 cm Stage II pressure ulcer noted to right heel, no drainage with partial thickness skin loss. Surrounding skin boggy Record review of Resident #64 wound care dated 1/9/2025 noted right heel pressure (ulcer) measuring: Length 1.72 cm and width 1.24 cm with eschar (black dead tissue). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #64's Minimum Data Set (MDS) significant change dated 1/9/2025 revealed Resident #64 with Brief Interview of Mental status (BIMS) score of 8 out of 15, impaired cognitive ability. Section GG Functional abilities: Coded 01. Dependent- Helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting, shower/bathe, upper/lower body dressing, putting on/off footwear, personal hygiene, and oral hygiene. Code 05. Set-up/clean-up assistance the helper sets up or cleans up, resident completes activity for eating. Section M Skin conditions: Assessed Resident #64 of developing 1 pressure ulcers/injuries, as unstageable pressure ulcer as slough and/or eschar known but not stageable due to coverage of wound bed by slough and/or eschar. Record review of the facility 'Nutritional Services Documentation' policy dated 9/19/2024 revealed that at least once a month and additionally as needed, the Nutrition Professional shall document in the dietary progress notes or appropriate assessment form the current nutritional status of residents with the following criteria: (e.) Stage 2 or higher-pressure injuries. In an interview and record review on 01/31/25 at 12:02 PM with the Registered Dietitian (RD) F record review of Resident #64's nutritional care plan noted nutritional supplement intervention on 2/20/2024, and that there were no other added interventions noted on the care plan related to the recent significant change of weight loss of 5.6% in a month. RD F reviewed the physician orders of 1/14/2025 of Med Pass ordered by the other RD G. Record review of the nutritional care plan revealed the order for Med Pass was not placed on the care plan. Resident #64 has stage 4 pressure ulcer to right heel and an unstageable black eschar pressure ulcer to medial outer foot. RD F was not aware of pressure ulcers for Resident #64. Record review of Resident #64's protein intake currently is at 46 grams which is only 58% of his daily protein requirements, which is inadequate to promote healing of pressure wounds. RD F stated that Resident #64's protein needs should be 80 grams daily. Record review of documented intake is less than 75%-0% per meals. Significant change in weight loss of 5.6%. RD F will plan to re-weight Resident #64 and the if he gains weight will add med pass to 3 x daily, if the resident does not gain weight, will add protein supplement Pro-stat 1 x daily (Pro-stat 19 gram/ml, needs 65 grams).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00149049. Based on observation, interview and record review, the facility failed to implement a restorative therapy program and develop a plan of care for restorative therapy for one Resident #97 of one reviewed for rehab and restorative therapy, resulting in the potential for functional decline, reduction in range of motion, diminished mobility and decreased independence. Findings include: Resident #97: A review of Resident #97's medical record revealed an admission into the facility on [DATE] with diagnoses that included anxiety disorder, depression, lymphedema, and open wound of lower leg. A review of the MDS, dated [DATE], revealed the Resident had intact cognition and needed substantial/maximal assistance with shower/bathing, was dependent with toileting hygiene, lower body dressing and putting on/off footwear, needed partial/moderate assistance with personal hygiene and transfers. On 1/30/25 at 9:32 AM, an interview was conducted with Resident #97 who was lying in bed with the head of the bed elevated. The Resident was asked questions, who answered and engaged in conversation. An observation was made of Resident #97's walker in the room. The Resident was asked if they used the walker. The Resident reported she had therapy that had stopped, and she had not received as many days as what was originally planned. When asked about a restorative therapy program, the Resident reported that therapy department indicated that facility staff will walk with her once per shift to build on the progress they had made. The Resident stated, Staff has not walked me. The Resident reported she had been using weights in therapy, but stated, I was never given that opportunity to follow through with exercises, and explained no weights were made available for her to use. The Resident asked why can't they use the exercise bike or get equipment like the weights to keep up her strength. A review of Resident #97's electronic medical record (EMR) revealed a Task for Nursing Rehab: Restorative plan-To maintain ability to walk Ambulation-up to 30 feet Device-front wheel walker 1 person assist. The document was able to be looked back from 1/1/25 to 1/30/25. The question How many feet did the resident walk? was documented on 1/1/25 for 10 feet, on 1/2/25 for 15 feet, and on 1/25/25 10 feet; there was 22 days documented as Not Applicable; and one day of refusal on 1/14/25. A review of the progress notes for 1/14/25 revealed no documentation of why the Resident had refused and/or interventions to address the refusal. The second question for the task was Amount of minutes spent training and skill practice in walking. The documentation revealed on 1/1/25 15 minutes, 1/2/25 15 minutes, and 1/25/25 15 minutes; one refusal on 1/14/25; and 22 days of Not Applicable. Further review of the medical record revealed Resident #97 did not have a care plan developed for Restorative Nursing Therapy, a plan to maintain walking ability and/or strengthening of extremities. The Resident's Kardex (resident care guide) revealed Mobility: Nursing Rehab: Restorative plan-To maintain ability to walk. Ambulation-up to 30 feet. Device-Front wheel walker, 1 person assist. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 11:20 AM, an interview was conducted with the Director of Nursing (DON) regarding the lack of Resident #97's restorative therapy plan. The DON reported the Resident had been on restorative therapy. The DON indicated that the Resident had been on starting on November 29 and indicated she was to be on for four weeks. When asked why the four weeks and why did the Resident not have a care plan to maintain strength, endurance and walking ability, the DON reviewed the medical record and indicated she was unsure and stated, She was supposed to be on one, (restorative therapy plan). The DON was asked for the instructions from therapy for the Restorative program, but the DON did not find the program in the electronic medical record. When asked if she should have a care plan for her restorative program that would include the plan to maintain ability to walk, the DON, indicated she should and reported she was working on a past non-compliance regarding Restorative Nursing Therapy but had not completed it. A review of facility policy titled Restorative Nursing, last revised 4/26/24, revealed, Purpose: The facility strives to enable the resident to attain and maintain the highest practicable level of physical, mental and psychosocial well-being. The Interdisciplinary team [IDT] works wit the resident and family to identify measurable restorative goals and practical interventions that can be implemented and achieved with nursing support . Nursing Restorative is available up to 6-7 times per week and is provided for residents meeting restorative program criteria . 6. Document any refusal in the resident's medical record. 7. Re-evaluate, at minimum quarterly . to determine if resident would benefit from restorative and if resident is willing and able to participate. 8. Identify restorative goals and interventions with input from the IDT and the resident and family/legal representative. 9. Document individualized restorative goals and interventions . 11. Document the resident's daily participation and actual number of minutes participating in the resident's EHR (electronic health record) .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22927 Based on observation, interview and record review, the facility failed to prevent weight loss for 1 resident (Resident #64) of 7 residents reviewed for nutrition, resulting in Resident #64 having a 5.6% weight loss, low protein diet with development of pressure ulcers. Findings include: Record review of the facility 'Nutritional Services Documentation' policy dated 9/19/2024 revealed that at least once a month and additionally as needed, the Nutrition Professional shall document in the dietary progress notes or appropriate assessment form the current nutritional status of residents with the following criteria: (e.) Stage 2 or higher-pressure injuries. Record review of the facility 'Weight Management' dated 9/22/2023 revealed residents will be monitored for significant weight changes on a regular basis. Residents are expected to maintain acceptable parameters of nutritional status, such as usual body weight and protein levels . The dietary manager and/or dietitian will calculate the monthly and weekly significant weight changes (5% in one month, 7.5% in three months, and 10% in six months). Resident #64: Observation on 01/29/25 at 9:50 AM of Resident #64 was lying in bed with breakfast meal tray on bedside table, no bites noted out of meal/foods, orange juice, milk, cereal soggy appearing. In an interview on 01/29/25 at 11:29 AM, Resident #64 stated that he had lost weight. Observed a carton of health shake on the over bed table. Resident #64 stated that his Hands are shaky and has hard time drinking the shake. In an observation on 01/30/25 at 08:14 AM, Resident #64 was noted to be lying in bed with No breakfast tray in room yet. Resident #64 stated that he eats his meals in bed. In an observation on 01/30/25 at 9:20 AM, Resident #64 was lying in bed with breakfast meal tray in front of resident no attempt to feed self. Resident #64 stated that his hands shake when he's eating, and no one helps him with meals. An interview on 01/30/25 at 02:51 PM with the Certified Dietary Manager (CDM) H revealed that the residents Weights were monitored by Registered Dietitian, Record review of Resident #64's weight log revealed on 12/11/2024 weight 156.1 and on 1/13/2025 weight 147.5 equal a loss of 5.7% weight in 33 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 01/30/25 at 03:01 PM, Registered Dietitian (RD) F revealed Nutritional evals are quarterly every 3 months and a full nutritional assessment annually. RD F was asked about Resident #64' weight loss was recently identified at 5.6% loss his weight decrease could be affected by diuretic and anti-psych meds. Record review of Resident #64's nutritional care plan for interventions: new order for med pass twice daily started on 1/14/2025, and health shake daily started 2/21/2024. Begin weights weekly after the significant weigh. change, and prior in December 2024 was monthly. Record review of the nutritional care plan Interventions should have been added med pass and Health shakes 1220 cal and 46-gram protein daily. Assist the dining is nursing service to feed the resident intake is done by CNA's. RD F stated that Monitoring intake is done by the RD, the Resident #64 eats 0% to 25% according to his intake record. RD F stated that he did trigger Resident #64 for a significant change due to weight loss today (1/30/2025). An interview and record review on 01/31/25 at 12:02 PM with the Registered Dietitian (RD) F and record review of Resident #64's nutritional care plan noted nutritional supplement intervention on 2/20/2024, and that there were no other added interventions noted on the care plan related to the recent significant change of weight loss of 5.6% in a month. RD F reviewed the physician orders of 1/14/2025 of Med Pass ordered by the other RD G. Record review of the nutritional care plan revealed the order for Med Pass was not placed on the care plan. Resident #64 has Stage 4 pressure ulcer to right heel and an unstageable black eschar pressure ulcer to medial outer foot. RD F was not aware of pressure ulcers for Resident #64. Record review of Resident #64's protein intake currently is at 46 grams which is only 58% of his daily protein requirements, which is inadequate to promote healing of pressure wounds. RD F stated that Resident #64's protein needs should be 80 grams daily. Record review of documented intake is less than 75%-0% per meals. Significant change in weight loss of 5.6%. RD F will plan to re-weight Resident #64 and the if he gains weight will add med pass to 3 x daily, if the resident does not gain weight, will add protein supplement Pro-stat 1 x daily (Pro-stat 19 gram/ml, needs 65 grams). 01/31/25 09:15 AM Observed resident with full meal tray in front of him: English muffin, with jelly, hash brown, corn flakes with milk, cream of wheat, orange juice, resident state he can't eat by himself, resident fell asleep while surveyor speaking with him.

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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** 37771 Based on observation, interview and record review the facility failed to ensure oxygen was provided as ordered for one resident (Resident #79) of 3 residents reviewed for respiratory care, resulting in the potential for inappropriate treatment with potential for adverse reactions . Findings include: Resident #79: A review of Resident #79's medical record revealed an admission into the facility on [DATE] with diagnoses that included dementia, diabetes, heart failure, pulmonary hypertension and chronic obstructive pulmonary disease (COPD). A review of the Resident's Minimum Data Set assessment revealed the Resident had severely impaired cognition and needed partial/moderate assistance with bathing, dressing, personal hygiene, sit to stand and bed to chair transfers. A review of Resident #79's orders revealed an order dated 1/22/25 for oxygen 2L (liters) to maintain oxygen saturation above 90% r/t (related to) COPD. A review of the Resident's care plan revealed a focus for .a potential for difficulty breathing and risk for respiratory complications . dated 2/27/24 with an intervention . Use 2 liters of oxygen via nasal cannula continuous . with revision done on 7/6/24. On 1/29/25 at 12:42 PM, an observation was made of Resident #79 sitting in bed. The Resident was observed to have oxygen nasal cannula positioned in her nose. The tubing to the oxygen was connected to the humidification. The humidification was not connected to the oxygen concentrator. The humidification did not have any bubbles to indicate the oxygen was connected correctly to deliver oxygen to the Resident. The Resident was asked if she could feel the oxygen at her nose but did not answer questions appropriately. Nurse V was summoned to the room. The oxygen tubing was shown to the Nurse where it was not connected. The oxygen tubing was connected back to the concentrator and the Nurse took the oxygen saturation (O 2 sat) that registered at 85% and increased to 90% they 95%. The Nurse indicated that the staff that changes out the oxygen tubing had recently been in the room and must have not connected it correctly. The Nurse reported that the oxygen was to be humidified, and the tubing will be replaced. On 1/31/25 at 12:08 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #79's oxygen not delivering the needed oxygen to the Resident. The DON indicated they were aware and that the staff had been talked about the changing of the tubing and connectivity.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to ensure that two Residents (#21, #83) received consistent pre and post dialysis weights, and failed to ensure that two Residents (#22, #107) received medications post dialysis when the residents returned to the facility from dialysis, resulting in the potential for decline in condition, lack of medication therapy, and prolonged health issues. Findings include: Record review of the facility 'Hemodialysis' policy dated 9/26/2023 revealed residents receiving hemodialysis will be assessed pre and post treatment and receive necessary interventions Record review of the facility 'Medication Administration' policy dated 10/17/2023 revealed resident medications are administered in an accurate, safe, timely and sanitary manner. Procedure: (6.) Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility Resident #107: Record review of Resident #107's December 2024 Medication Administration Record (MAR) noted that on 12/3/24, 12/5/24, 12/7/24, 12/10/24, 12/12/24, 12/14/24 and 12/17/24 Resident #107 did not receive medications of Norvasc 10 mg (blood pressure), pantoprazole 40 mg (GERD), Valsartan 160 mg (blood pressure), Coreg12.5mg (blood pressure), Eliquis 2.5 mg (blood thinner), Nepro 2 times daily (dialysis), Reglan 5 mg (nausea), and sevelamer carbonate 2.4 grams (dialysis) were not administered on those dialysis days as ordered by physician. Record review of Resident #107's January 2025 Medication Administration Record (MAR) noted on 1/25/25, 1/28/25 that Aspirin 81 mg, Folic Acid 1 mg, Norvasc 10 mg (blood pressure), pantoprazole 40 mg (GERD), Valsartan 160 mg (blood pressure), Coreg12.5mg (blood pressure), Eliquis 2.5 mg (blood thinner), Nepro 2 times daily (dialysis), and sevelamer carbonate 2.4 grams (dialysis) were not administered on those dialysis days as ordered by physician. An interview and record review on 01/31/25 at 01:52 PM with the Director of Nursing (DON) revealed Resident #107's December 2024 and January 2025 Medication Administration Record (MAR) of missed medications. The DON stated that she could not explain why the nurses are not giving the resident medications on dialysis days before going to dialysis or why after the resident comes back. The DON stated that she will have to educate the nurses on changing med times. 37666 Resident #21 Dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #21 was admitted to the facility on [DATE] with diagnoses: history of a stroke with left-sided weakness, Dementia, diabetes, chronic kidney disease, need for dialysis, feeding tube, history of seizures. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 0/15 and the resident needed assistance with all care. ON 1/30/2025 at 10:33 AM, Resident #21 was observed lying in bed, awake. He did not verbalize answers to questions, but would point or make gestures. Nurse aide M was with him and said she was going with the resident to dialysis and they were waiting for the transport to arrive. The nurse aide said the resident went to dialysis on Monday, Wednesday, and Friday and needed someone to go with him because he would become restless and try to get out of the chair and fall. The resident was asked where his dialysis catheter was and he pointed to his left groin; the nurse aide confirmed that was where his catheter was. The resident pointed to his abdomen and a feeding tube was observed. On 1/30/2025 at 2:51 PM, Registered Dietitians/RD F and G were interviewed about Resident #21's weight. He weighed 120.8 lbs. on 1/6/2025. RD G said the resident had experience a weight loss over several months. RD G said she used the resident's weights on the Dialysis Communication Forms to determine the resident's nutritional status. The weight was obtained pre and post treatment on Monday, Wednesday and Friday when the resident went to dialysis. The RD G said the dialysis center did not always document the weights on the resident's Dialysis Communication Form and the last weight in the Weights and Vitals section of the electronic medical record for Resident #21 was dated 1/6/2025. A record review of the electronic medical record for Resident #21 indicated the most recent Dialysis Communication Form was dated 12/27/2024. A review of the Dialysis Communication Forms indicated they were not consistently completed. Many were missing pre or post or pre and post dialysis weights. Some of the forms were mostly blank. Resident #83 Dialysis A record review of the Face sheet and MDS assessment indicated Resident #83 was admitted to the facility on [DATE] with diagnoses: Diabetes, end stage kidney disease, need for dialysis, anxiety, depression, absence of left leg below the knee due to amputation, and heart failure. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of 15/15 and needed some assistance with care. On 1/30/2025 at 9:05 AM, Resident #83 was observed sitting in his wheelchair in the hallway. He said he went to dialysis on Monday, Wednesday and Friday. A record review of the electronic medical record for Resident #83, revealed there was one Dialysis Communication Form in the medical record dated 11/11/2024. A review of the weight for Resident #83 indicated they were obtained less than weekly at the facility and the last weight was dated 1/21/2025 with a weight of 208.2 lbs. The resident had gained 8.6 lbs. from the prior weight on 1/9/2024. A review of the Care Plans for Resident #83 identified the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Resident #83) is at risk for complications related to needs dialysis due to : possible infection, CKD/chronic kidney disease, date initiated 11/7/2024 and revised on 11/8/2024 with Interventions: Dialysis, with pickup time of 11 am and chair time 1130 am, dated 12/2/2024; For Hemodialysis: Facility will utilize the Dialysis Communication form to communicate with the dialysis center . date initiated 11/12/2024; For Hemodialysis: Obtain daily weights as ordered. Notify physician of weight changes per physician ordered parameters, date initiated 11/12/2024; Observe for signs of fluid retention: peripheral edema, weight gain . dated 11/7/2024. On 1/30/2025 at 3:26 PM, RD F was interviewed about Resident #83. He said the resident was monitored for weight loss or gain, but the weights were not consistently obtained. The dialysis center did not always provide pre and post dialysis weights and the facility did not obtain pre and post dialysis weights. He said the resident had experienced a weight gain possible related to fluid build up. 37771 Resident #22: A review Resident #22's medical record revealed an admission into the facility on [DATE] and readmission on 1/22/25 with diagnoses that included chronic kidney disease with dependence on renal dialysis, dementia, bradycardia, seizure disorder or epilepsy, and hypertensive chronic kidney disease. A review of the Minimum Data Set assessment dated [DATE] revealed the Resident had severely impaired cognition and needed substantial/maximal assistance with eating, toileting hygiene, bathing, dressing, roll left and right, sit to lying, lying to sitting. A review of Resident #22's medical record revealed the Resident went to dialysis on Tuesday, Thursday and Saturday. The Resident had been transferred to the hospital on 12/31/24 and returned to the facility on [DATE]. A review of Resident #22's Medication Administration Record (MAR) revealed medications scheduled in the morning at 9:00 am and 11:00 am were not always given on the days the Resident was scheduled for dialysis and not documented as given before leaving or after returning to the facility. The facility did not accommodate the Resident's dialysis treatments in the medication regimen. Review of the January 2025 MAR included the following: -Doxazosin 2 mg (milligram), give 2 tablets one time a day for hypertension, scheduled at 9:00 am on 1/8 then changed to 11:00 am. The following days were documented with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. -Escitalopram Oxalate 10 mg, given 1 tablet one time a day for depression, scheduled at 9:00 am on 1/8 then changed to 11:00 am on 1/9. The following days were documented with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. -Furosemide 20 mg, give 1 tablet by mouth one time a day for diuretic, scheduled at 9:00 am on 1/8 then changed to 11:00 am on 1/9. The following days were documented with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Losartan 50 mg, give 1 tablet one time a day for hypertension, scheduled at 9:00 am on 1/8 then changed to 11:00 am on 1/9. The following days were documented with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. -Colace 100 mg, give 1 capsule two times a day for bowel regimen, scheduled at 11:00 am and 9:00 pm. The following days were documented on the 11:00 am administration with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. -Levetiracetam 250 mg, give one tablet two times a day for epilepsy, scheduled at 11:00 am and 9:00 pm. The following days were documented on the 11:00 am administration with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. -Midodrine 5 mg, give one tablet two times a day for hypotension, scheduled at 11:00 am and 5:00 pm. The following days were documented on the 11:00 am administration with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. -Nifedipine Extended Release 60 mg, give one tablet by mouth two times a day for hypertension, scheduled at 11:00 am and 9:00 pm. The following days were documented on the 11:00 am administration with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. -Quetiapine Fumarate, 25 mg, give one tablet by mouth two times a day for depressive disorder, scheduled at 11:00 am and 9:00 pm. The following days were documented on the 11:00 am administration with a 3, which indicated Absent from Home, 1/9, 1/11, 1/16, 1/18, 1/21, 1/23, 1/25, 1/28, 1/30. On 1/31/25 at 11:33 AM, an interview was conducted with the Director of Nursing (DON) regarding Resident #22 and the lack of accommodations of medication regimen with dialysis treatments. The DON indicated that the medications should be given when returned or earlier in the mornings. The DON indicated that the Resident was picked up at 8:15 for a chair time at dialysis at 9:00 am and gets back about 1:00 pm.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to ensure suicide precautions were ordered, for one Resident #32 of one resident reviewed for mood and behavior, resulting in the potential for a lack of continuity of care and an adverse outcome for Resident #32. Findings Include: Resident #32: Behavioral-Emotional On 1/29/2025 at 10:34 AM, Resident #32 was observed lying in bed. When asked where her call light was, she said the staff took it and gave her a bell to ring. A small bell was observed on the bedside table. When asked why they gave her the bell, she said she didn't know. On 1/29/2025 at 10:39 AM, Nurse Aide L was asked why Resident #32 did not have a call light and she said the resident was on suicide watch as of that morning 1/29/2025. She said a nurse took her call light so she did not have any long cords to hurt herself and gave her a bell. She said she didn't know any more than that. On 1/29/2025 at 10:45 AM, Nurse K was interviewed about Resident #32 being on suicide watch. She said the resident threatened to harm herself and her call light was removed, and a bell was given. Nurse K was asked what precautions were in place for Resident #32 and she said the staff were monitoring her every 15 minutes. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #32 was admitted to the facility on [DATE] with diagnoses: Cerebral Palsy, Major Depressive disorder, Bipolar disorder, heart failure, diabetes, chronic kidney disease, morbid obesity, epilepsy, and COPD. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and needed assistance with care. Further review indicated Resident #32 had discharged to the hospital on multiple occasions since admission. A record review of the medical record for Resident #32 indicated there was no mention on the Care Plan that Resident #32 was on suicide precautions to ensure staff were monitoring her and providing interventions to aid in prevention of suicide or that her call light was taken away and replaced with a bell. There was no mention of 15-minute checks. A review of the progress notes for Resident #32 identified the following: 1/29/2025 no time, a provider note by NP O, Patient went out to the hospital last night for suicidal ideation, and was sent right back, patient is asking to go to the hospital again for suicidal ideation with plans. Patient is following with psych at the facility. Recommended that the patient be sent back out for suicidal ideation. Rounding team notified. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/2025 at 2:58 AM, a nurses note Resident states that she wants to kill herself. Writer attempted to talk to pt (patient) and see if she has a plan. Resident told writer that she wants to go to hospital because there was nothing we can do for her here. 15 minute checks initiated immediately. On call provider notified and ordered for pt to be sent out. DON (Director of Nursing) notified of transfer. 1/29/2025 no time, a provider note by Nurse Practitioner/NP N, . Per nursing, patient was sent to hospital overnight due to suicidal ideation. She was returned to facility with no changes in medications. Per facility protocol, suicide precautions attempted to be placed. Patient stated, You will not be taking my call light. I'm not going to do anything to myself. Attempted to re-educate patient on policy, to which patient replied, I just need to get out of here. I want to go to the hospital . I'm going to kill myself here . A review of the physician orders on 1/29/2025 at 12:00 PM, indicated there was no order for suicide precautions for Resident #32, to ensure all staff were monitoring and aware of necessary precautions and interventions. A Social Service note dated 1/29/2025 at 10:39 AM, SW was informed that the resident was sent out last night for suicidal ideations. The resident was placed on 15-minute checks and suicidal precautions . SW provided active listening . Call light and light cords were removed from the room and a bell was provided . On 1/30/2025 at 4:40 PM, the DON was interviewed about Resident #32. She said the resident was on suicide precautions and the staff were performing 15-minute checks on the resident. Reviewed with the DON, the Care Plans for Resident #32 did not indicate there were suicide precautions and reviewed there were no orders for suicide precautions. The DON said the resident had been on suicide precautions twice since November 2024. The DON was asked where the documentation for 15- minute checks was, as it could not be located in the resident's medical record, the DON said it was documented on paper at the nurse's desk. She said the Social Worker and Activities staff were to see the resident daily. On 1/30/2025 at 6:45 PM, a nurses note provided, Writer notified the on call provider regarding the resident holding her breath to attempt self harm. Per on call provider send resident to ER for further evaluation. DON aware. Physician orders for 15-minute checks for Resident #32 and an order for suicide precautions was dated 1/30/2025 at 7:15 PM; this was more than 24 hours after the resident had threatened to harm herself. The order for suicide precautions stated, Suicide precautions as needed for safety per resident verbal communication as needed for verbal expression of suicidal ideations, start date 1/30/2025 at 7:15 PM. On 1/31/2025 at 11:50 AM, Staff Education Nurse P was interviewed and said the staff had not received education on suicide precautions. (continued on next page)

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	235343	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kith Haven	G 1069 Ballenger Hwy Flint, MI 48504

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Suicide/Self-Harm Attempt, dated revised 9/26/2023 provided, To identify warning signs of suicide/self-harm and protect resident from harm . Most suicide attempts are preceded by warning signs. Do not ignore Warning signs. Suicide/self-harm attempts and completed suicides have occurred in nursing facilities . At such time that signs and/or symptoms of suicide or self-harm are exhibited, the resident is not to be left unattended (immediately place on 1:1 supervision) . Update care plan as needed . planned interventions, safety precautions.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on interview and record review, the facility failed to ensure that pharmacist medication regime reviews (MRR) were reviewed, acted upon and addressed in the residents' clinical record for five (#27, 40, 42, 86, 102) of five residents reviewed for MRR. resulting in medications not being adjusted with physician response to accept or decline the pharmacy recommendations. Findings Include: Resident #27 On 1/29/2025 at approximately 2:15 PM, a review was conducted of Resident #27's medical record and it indicated the resident admitted to the facility on [DATE] with diagnoses that included Alzheimer's, Adjustment Disorder, Delusional Disorder, Dementia, Adjustment Disorder and Major Depressive Disorder. On 1/30/2025 at approximately 4:00 PM, a review was conducted of Resident #27's monthly pharmacy recommendations from May 2025 to December 2024. The pharmacist noted an irregularity on 9/24/2024 but the specifics were not in the resident medical record. On 1/31/2025 at 10:13 AM, an interview was conducted with the DON (Director of Nursing) regarding monthly pharmacy recommendations. She explained contact was made with their pharmacist who emailed the recommendation which was addressed timely for Resident #27 in early October 2024; but they do not have the signed copies of them within the medical chart nor is there a subsequent binder for other residents MRR. Resident #86 On 1/30/2025 at approximately 4:15 PM, a review was conducted of Resident #86's monthly pharmacy recommendations from May 2025 to December 2024. The pharmacist noted irregularities in March 2024, May 2024 and October 2024 but the specifics of their recommendations were not located in Resident #86's medical record. The facility provided pharmacy consultation reports that were unsigned by the physician and DON: 3/26/2024: .Please consider discontinuing Senna and docusate and adding PEG 3350 17 gms qd and titrating to BID if needed . 5/28/2024: .Please monitor for involuntary movements now and at least every 6 months or per facility protocol. It is recommended that monitoring frequency increase following dose adjustments . 10/29/2024: .Please monitor for involuntary movements now and at least every 6 months or per facility protocol. It is recommended that monitoring frequency increase following dose adjustments . 37666 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 Unnecessary Meds, Psychotropic Meds, and Med Regimen Review A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #40 indicated an admission to the facility on [DATE] with diagnoses: Diabetes, kidney disease, anemia, hypertension, anxiety, depression, psychiatric disorder. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 1/15 and needed assistance with care. On 1/30/2025 at 1:53 PM, during a record review of the Medication Regimen Reviews/MRR for Resident #40, it was identified there were 4 MRR recommendations from the monthly MRR reviews over the past year. The recommendation dates identified by the facility pharmacist included: 3/11/2024, 5/28/2024, 10/30/2024 and 1/30/2025 (which was newly completed). Of the 3 recommendations in 2024, the Director of Nursing was able to provide a copy of the pharmacy recommendation for one date: 10/30/2024. The recommendations for 3/11/2024 and 5/28/2024 were not located by the facility and it could not be determined what they were or if the physician/provider reviewed them and acted upon them. Resident #42 Unnecessary Meds, Psychotropic Meds, and Med Regimen Review A record review of the Face sheet and MDS assessment indicated Resident #42 was admitted to the facility on [DATE] with diagnoses: Alzheimer's, depression, COPD, Heart Disease and Non traumatic brain injury. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of 15/15. On 1/30/2025 at 1:23 PM, the monthly Medication Regimen Reviews/MRR reviewed indicated 2 of the reviews had recommendations: 1/28/2025 (newly completed) and 12/31/2024. Neither recommendation could be located in the medical record for Resident #42. On 1/30/2025 at 2:30 PM, the Director of Nursing/DON was asked about the pharmacy reviews for Resident #40 and Resident #42. She said she would look for them. On 1/31/2025 at 10:30 AM, the DON said she found 1 pharmacy review for Resident #42 dated 12/31/2024. The recommendation from the pharmacist was Please obtain a BMP (bloodwork) on the next convenient lab day and every 6 months thereafter. The provider signed the document with I accept the recommendations above, please implement as written, on 1/3/2025 and the DON signed on 1/8/2025. During a review of the medical record for Resident #42, a laboratory result with a BMP (basic metabolic panel- which included electrolytes, glucose and tests for kidney function), were not located. The last blood work in the resident's chart was dated 6/12/2024. 22927 Resident #102: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #102's January 2025 Medication Administration Record revealed that the resident received: Ativan 0.5 mg tablet twice daily for anxiety and agitation; Depakote sprinkles 125 mg twice daily for psychotic disorder and delusions. Zyprexa 7.5 mg tablet twice daily for restlessness and agitation. Record review on 01/30/25 at 01:36 PM of Resident #102's pharmacy reviews from April 2024 through January 2025 revealed there to be no reviews for the months of June 2024 and August 2024 found for the resident. An interview on 01/31/25 at 12:53 PM with the Director of Nursing (DON) of Resident #102's Medication regimen review for a year look back revealed there were no June 2024 or August 2024 reviews found in the computer. The DON stated that at this point 6 months past those months the medication reviews should have been there (in the computer system). The DON stated that she did learn about looking up the monthly reviews. The Pharmacy consultant does the monthly and/or admission reviews. The DON stated that she could not know if there were any pharmacy recommendations for those months of June 2024 or August 2024 for that resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on interview and record review the facility failed to ensure informed consent was obtained prior to administration of psychotropic medications for three (#27, #90 and #102) of five residents reviewed for unnecessary medications. Findings Include: Resident #27 On 1/29/2025 at approximately 2:15 AM, a review was conducted of Resident #27's medical record and it indicated the resident admitted to the facility on [DATE] with diagnoses that included Alzheimer's, Adjustment Disorder, Delusional Disorder, Dementia, Adjustment Disorder and Major Depressive Disorder. Further review yielded the following: Physician's Orders: Risperidone Tablet 0.25 MG (milligram)- give one table by month two times a day for psychotic disorder with delusion due to known psychological. Ordered on 10/17/2024. On 1/30/2025 at 2:50 PM, Social Work Director E was asked about their process regarding psychotropic medication consents. It was explained they only complete consents for antipsychotic medications. Review was completed of Resident #27's chart which indicated she is prescribed Risperidone (an antipsychotic) for psychosis. When looking under the resident's diagnosis tab there was not a diagnosis listed of psychosis. Director E looked as well and was not able to located the proper diagnosis to accompany the usage of the antipsychotic. The director was then asked to provide Resident #27's consent for Risperidone and she stated she was not able to locate the consent for Risperidone. 22927 Resident #90: Record review of Resident #90's January 2025 Medication Administration Record revealed that the resident received: Latuda (Lurasidone) 20mg tablet daily for delusional disorder. Zoloft (Sertraline) 25mg tablet daily for depression. Medical conditions included: Delusional disorder, vascular dementia unspecified severity with agitation, paranoid schizophrenia, adjustment disorder with depressed mood. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and records review on 01/31/25 at 09:24 AM with social worker S of Resident #90 and Resident #102 revealed that the facility did not use consents forms for anti-depressants or anxiety medications, even though the medications can have an effect/influence on the residents' behaviors/moods. Review of Resident #90 was treated for paranoid schizophrenic, paranoid delusional disorder and adjustment disorder with depressed mood. Resident #102 was treated for psychotic disorder with delusional psychological condition, mood disorder, depressant features, anxiety disorder, major depress disorder, anxiety disorder, restlessness, agitation, traumatic brain injury. Social worker S stated that the facility use consents for the psychotropic meds only. Resident #102: Record review of Resident #102's January 2025 Medication Administration Record revealed that the resident received: Ativan 0.5mg tablet twice daily for anxiety and agitation. Depakote sprinkles 125mg twice daily for psychotic disorder and delusions. Zyprexa 7.5mg tablet twice daily for restlessness and agitation. Medical conditions included: Major depressive disorder, General Anxiety disorder, Restless and Agitation, Mood Disorder due to unknown physiological condition with depressive features, anxiety disorder due to unknown physiological condition, psychotic disorder due to unknown physiological condition, history of traumatic brain injury, vascular dementia moderate with other behavioral disturbance, dementia in other disease classified elsewhere, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review on 01/30/25 at 01:36 PM of Resident #102's pharmacy reviews from April 2024 through January 2025 revealed there to be no reviews for the months of June 2024 and August 2024 found for the resident. In an interview on 01/31/25 at 12:53 PM with the Director of Nursing (DON) of Resident #102's Medication regimen review for a year look back revealed there were no June 2024 or August 2024 reviews found in the computer. The DON stated that at this point 6 months past those months the medication reviews should have been there (in the computer system). The DON stated that she did learn about looking up the monthly reviews. The Pharmacy consultant does the monthly and/or admission reviews. The DON stated that she could not know if there were any pharmacy recommendations for those months of June 2024 or August 2024 for that resident. Record review of the facility provided 'Antipsychotic Risk Benefit Medication Evaluation' clinical guideline form 106.02 (undated) revealed diagnosis included schezohophrenia, psychotic mood diorder, delusional disorder hallucinations, paranora and deliruim were noted on the form.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on interview and record review, the facility failed to follow standards of practice and physician orders of parameters for blood pressure (BP) and heart rate (HR) when administering medication to one resident (Resident #22), of six residents reviewed for medication regimen review, resulting in the potential for adverse medication reactions, bradycardia (low heart rate), and re-hospitalization . Findings include: Resident #22: A review Resident #22's medical record revealed an admission into the facility on [DATE] and readmission on 1/22/25 with diagnoses that included chronic kidney disease with dependence on renal dialysis, dementia, bradycardia, seizure disorder or epilepsy, and hypertensive chronic kidney disease. A review of the Minimum Data Set assessment dated [DATE] revealed the Resident had severely impaired cognition and needed substantial/maximal assistance with eating, toileting hygiene, bathing, dressing, roll left and right, sit to lying, lying to sitting. A review of Resident #22's medical record revealed the Resident went to dialysis on Tuesday, Thursday and Saturday. On 12/30/24 the Hemodialysis Communication Form indicated Pulse down to 35, sent patient to ER. On 9/24/24 at 3:37 PM, Nurses Notes: Resident sent to hospital from dialysis and Nursing Summary on 10/7/24 at 3:01, Resident is a readmission from (hospital name) where he was seen for bradycardia . A review of History and Physical Report, dated 9/25/24, revealed, .Chief Complaint: Pt became bradycardic during dialysis . According to reports, patient found to be bradycardic with heart rates into the 40's . A review of discharge hospital records for 1/7/25 revealed, Discharge Diagnosis: 1: Symptomatic bradycardia . A review of Resident #22's Medication Administration Record (MAR) for January 2025 revealed the following: -Order for Nifedipine Extended Release 60 mg (milligrams), give 1 tablet by mouth two times a day for hypertension Hold for SBP (systolic blood pressure) <100, HR <50. Documented as given on 1/15/25 11:00 AM with BP (blood pressure) 171/69 and HR (heart rate) 45; 1/16/25 9:00 PM with BP 128/47, HR 45; 1/26/25 at 9:00 PM with BP 98/44, HR 47; 1/30/25 with 154/58, HR 45. The medication was documented as given when the vital signs were not within the range as ordered by the practitioner. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Order for Doxazosin 20mg, give 2 tablets one time a day for hypertension. The parameters for the medication had been to hold for SBP <100 with a start date on 10/30/24 and discontinued on 1/3/25 when the Resident had transferred to the hospital. The parameters were not applied to the Doxazosin after returning from the hospital. On 1/27/25 at the 11:00 am administration, the documented BP was 98/44 with a HR of 47 and the medication was documented as given. This was the same documented BP and HR from the administration of Nifedipine at the 9:00 pm administration. -Order for Midodrine 25mg, give one tablet by mouth two times a day for hypotension hold for b/p (blood pressure) >110, with a start date on 1/8/25. (Midodrine-Alpha-1-Agonist medication used for blood pressure support, often used to treat low blood pressure.) The medication was documented as given on 1/12/25 at 11:00 AM with BP 175/69, HR 60 and on 1/13/25 at 11:00 AM, with BP 129/59 and HR 59. A review of Resident #22's medication administration for the order Metoprolol Tartrate tablet, give 12.5 mg by mouth two times a day for hypertension. Hold for SBP <100, HR <55, with a start date on 10/22/24 and discontinued on 11/7/24. (Metoprolol Tartrate- a type of Beta blocker often used to treat hypertension and can cause lowering of the heart rate). The medication was documented as given on 10/23/24 9:00 AM with BP 133/75 and HR 53; 10/24/24 at 9:00 PM with BP 185/73 and HR 50; 10/27/24 at 9:00 AM with BP 176/86 and HR 54; 10/27/24 at 9:00 PM with BP 232/99 an HR 53; 1/28/24 at 9:00 AM with BP 177/69 and HR 42; 11/1/24 at 9:00 AM with PB 203/73 and HR 39; 11/2/24 at 9:00 AM with BP 173/78 and HR 51; 11/4/24 at 9:00 PM with BP 166/70 and HR 49; 11/5/24 at 9:00 AM with BP 123/68 and HR 54, 11/5/24 at 9:00 AM with BP 178/74 and HR 50; and 11/7/24 at 9:00 AM with BP 164/73 and HR 51. On 1/31/25 at 11:33 AM, an interview was conducted with the Director of Nursing (DON) regarding Resident #22's medications with parameters. The Resident had been hospitalized in September due to bradycardia during dialysis and then on December 30th the Resident went to the hospital again with heart rate of 35 and returned with diagnosis of symptomatic bradycardia. The administration of Metoprolol documented as given when outside of the ordered parameters, after the Resident had been transferred out to the hospital prior with bradycardia, was reviewed with the DON. Midodrine used for hypotension but given outside the parameters to hold if greater than 110, was reviewed. The DON reported indicated that the Nursing staff needed to use nursing skills and know the signs and symptoms and what the medications were for and reach out to the doctor with orders. The DON indicated that the Nurses should be following the parameters and reaching out to the doctor with any concerns. A review of facility policy titled, Medication Administration, effective 10/17/23, revealed, .Physician's Orders-Medications are administered in accordance with written orders of the attending physician. If a dose is inconsistent with the resident's age and condition or a medication order is inconsistent with the residents current diagnosis or condition, contact the physician for clarification prior to administration of the medication. Document the interaction with the physician in the progress notes and elsewhere in the medical record, as appropriate . 5. If applicable and/or prescribed, take vital signs or tests prior to administration of the dose, e.g. , pulse with digitalis, blood pressure with anti-hypertensive, etc .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to ensure that medications were appropriately stored in 3 of 3 Medication carts, and an unlocked treatment cart, resulting in a opened and unsecured treatment cart, opened and undated medications, lack of appropriate storage with loose tablets noted in carts, of temperature sensitive medications with irregular refrigerator temperature monitoring, and the potential for residents to receive medications with altered efficiency and potency. Findings include: Record review of the facility provided 'Medication Storage Guidance' form dated 2024, revealed that multi-dose vials for injection are dated when opened and discard unused portion after 28 days or in accordance with manufacture's recommendations . Record review of the facility 'Vaccine Storage Temperature Log' form dated January 2025 revealed instructions: Place a check in the box that corresponds with the temperature (rows), day of the month, and am or pm (columns) for your temperature check. Then enter your initials and the time you monitored the temperature in the boxes at the top of the chart. Observation and interview on 01/29/25 at 10:02 AM with Licensed Practical Nurse (LPN) V of the second-floor north medication cart revealed: Resident #40 to have Lispro insulin dated 12/17/2024, LPN V stated that's only good for 28 days after opening. Resident #43 (unsampled) had a bottle of liquid Valproic acid 16 oz. 250mg/5ml that was opened and not dated, observed less than 16 oz. in the bottle. Resident #21 had a bottle of liquid Valproic acid 250mg/5ml bottle not dated estimated 20ml left in bottle, also had a bottle of liquid oxcarbazepine 300mg/5ml, opened and not dated. New Resident unsampled had a bottle of liquid Valproic acid 250mg/5ml, opened and not dated. Resident #42 had a bottle of Lactulose 10gm/15ml opened and not dated. Review of the second-floor medication cart revealed there to be 4 loose tablets, (3 white and 1 pink). Observation and interview on 01/29/25 at 10:02 AM with Licensed Practical Nurse (LPN) W of the third-floor north medication cart revealed: top drawer insulins- (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #71 had Lispro insulin bottle opened not dated. LPN W did not know when the insulin had been opened. Resident #118 (unsampled) had liquid Risperidone 1ml/ml bottle opened and not dated. Resident #102 had liquid bottle of levetiratracin 100mg/ml that was opened and not dated. There was also a Bryna 160/4.5mcg inhaler used with the seal broken and not dated. Resident #31 (unsampled) had Albuterol sulfate HFA 90 mcq inhaler was used with no date when opened. Resident #92 had Symbicort 160/4.5mcq inhaler that was opened and used with no date when opened. Review of the third-floor medication cart revealed there to be 1 white loose tablet found on bottom of 2nd cart drawer. Observation and interview on 01/29/25 at 11:35 AM The state surveyor stepped on a white tablet on the floor of the 300 hallways in front of room [ROOM NUMBER]. Licensed Practical Nurse (LPN) W was at the medication cart in the hallway and took care of the white round tablet, stating 'that is Tylenol tablet, I don't know how that got there'. Observation and interview on 01/30/25 at 07:50 AM with Licensed Practical Nurse (LPN) X of the first-floor north medication cart revealed: Resident #37 (unsampled) had Glargine insulin bottle 100units/ml, 10ml bottle opened with top off and puncture marks noted in top undated. Fluticasone 50mcg nasal spray with the seal broken and used with no open date. Resident #65 had Lispro insulin 100units/ml with no date on bottle noted top off with puncture marks noted in rubber stopper, Ipratropium Bromide 0.5mg aerosol treatment ampules a box of 30 with some missing with no date when opened. Resident #74 (unsampled) had Nitroglycerin 0.4mg tablets with red seal strip removed and no date of when opened that was Dispensed date of 12/18/2024. Record review of first floor north Medication room with Licensed Practical Nurse (LPN) X revealed an Omni cell tower with nurse passwords and to remove a Narcotic takes 2 nurses. Review of medication refrigerator noted tuberculin purified protein derivative opened with puncture marks in rubber stopped with no date on the bottle when opened. Record review of the first-floor north refrigerator temperature checks log for January 2025 noted 9 shifts failed to consistently check the medication refrigerator temperatures. Dates missing: 1/15/25 AM shift, 1/19/25 PM shift. 1/20/25 PM shift, 1/21/25 AM shift, 1/22/25 AM shift, 1/23/25 AM shift, 1/24/25 AM shift, 1/27/25 AM shift, 1/28/25 AM shift. Observation and interview on 01/30/25 at 10:08 AM with Licensed practical Nurse Z of the 2 south medication room refrigerator noted Tuberculin Purified derivative opened and undated with puncture marks on the rubber stopper and that the refrigerator temperature log for January 2025 was not checked consistently the medication refrigerator temperatures. Dates missing: 1/21/25 AM shift, 1/23/25 AM shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kith Haven	G 1069 Ballenger Hwy Flint, MI 48504

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37771 Treatment cart not secured: On 1/29/25 at 11:40 AM, an observation was made in the 300 hall area of a treatment cart that was stored in an area near the nurses station and adjacent to the common area. The treatment cart was unlocked, and a drawer was partially opened. The treatment cart did not have a Nurse attending to the unsecured cart. Two Residents were in wheelchairs in the common area watching TV and there were Residents in the vicinity of the unsecured treatment cart. Staff were at the Nurses station but left the area. A Resident was observed to be propelling himself in the area and passed by the open treatment cart. On 1/29/25 at 11:47, the Nurse returned to the area and was asked about the unsecured treatment cart. The drawers were able to be opened on the cart and an observation was made of dressing supplies for wounds, treatments and prescribed treatments. The Nurse indicated the treatment cart should be locked and secured the treatment cart.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure timely dental services were provided and communicate with dental services regarding the need for dental x-rays for one resident (Resident #97), of one resident reviewed for dental services, resulting in a broken tooth not repaired/extracted, pain, infection and the Resident's lack of knowledge of the plan of care. Findings include: Resident #97: A review of Resident #97's medical record revealed an admission into the facility on [DATE] with diagnoses that included anxiety disorder, depression, lymphedema, and open wound of lower leg. A review of the MDS, dated [DATE], revealed the Resident had intact cognition and needed substantial/maximal assistance with shower/bathing, was dependent with toileting hygiene, lower body dressing and putting on/off footwear, needed partial/moderate assistance with personal hygiene and transfers. On 1/30/25 at 9:32 AM, an interview was conducted with Resident #97 who was observed to be in bed with the head of the bed elevated. The Resident was asked and answered questions and engaged in conversation. The Resident was asked about issues with eye and dental services. The Resident reported she had broken a tooth back around Thanksgiving and had not had it fixed or taken out and did not know what how, what or when it was going to be taken care of. An observation was made of a tooth on the Resident's upper left side of a tooth that was broken lengthwise and was pointed on the end. The Resident was asked if she had any pain or sensitivity and indicated she did have pain with it and had an infection as well. The Resident expressed frustration of not knowing when she would see the dentist and if they were going to pull it, if it could be done here or would she have to go out to get it fixed. A review of Resident #97's medical record revealed document from Dental Group with exam completed on 12/2/24 by the Registered Dental Hygienist. Treatment Notes revealed, Assessment and Prophy; . moderate calculus, plaque and bleeding; bleeding controlled with gauze; areas of demineralization; remaining roots and broken teeth are asymptomatic; gingiva is pink to dark pink, shiny and slightly puffy; recommend dry brushing from bed as necessary . deep fracture at #10 is painful when eating and feels sharp to her tongue . (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 12:41 PM, an interview was conducted with Social Worker (SW) S regarding Resident #97's dental needs. A review of the Resident's medical record revealed the documentation from the hygienist. The SW indicated that the Resident was on the list to be seen by the dentist and the dentist was scheduled to be at the facility on 1/29/25. The SW did not know if the Resident had a plan to have the tooth pulled and did not think the dentist had come on 1/29. The SW put a call into the special service group to inquire about the plan for Resident #97 and the next visit from the dentist. Dental Group Staff T reported that the dentist had canceled and rescheduled for February 5th. The Dental Group Staff reported that the hygienist had seen the Resident on December 2nd, and the tooth was identified as a problem and requested to be seen by the dentist who seen the Resident on 12/9/24. The SW asked for the paperwork for the 12/9 visit which had not been given to the facility. The Dental Group Staff reported that the plan was to get x-rays taken and the dentist can't do anything until the x-rays were completed. The Dental Group Staff reported they had no hygienist available to do the x-rays. The SW reported that the facility was not made aware there was x-rays that needed to be completed or that the dental group did not have a hygienist to do the x-rays. The SW discussed options to get the x-rays prior to the dentist's upcoming visit so as when the dentist comes, treatment was not delayed longer. A review of the Resident that broke a tooth in November, seen by the hygienist and dentist in the beginning of December, but the facility and the Resident was not notified of when x-rays will be taken and a lack of available hygienist to do the x-rays that are needed prior to further treatment plans on extraction at the facility or if the Resident has to go out of the facility for extraction with a delay in treatment for needed dental services. The SW stated, We need to have a plan for her, and reported will see if they get a response back for another hygienist to do the x-rays. A review of Resident #97's Dental Group document with service on 12/9/24 by Dentist revealed, .Treatment Notes: .Carious fracture in #10 and 28, patient complains of pain with mastication due to sharp edges of fractured #10. Tooth is not restorable. Recommending extraction and fabrication of upper partial denture . FMX (full mouth x-ray) needed in order to properly diagnose treatment. If no radiographs before next visit, #10 will just be smoothed down, if patient is not open to extracting it that visit . Recommended treatment: . Extractions: tooth #10 .FMX .X-Ray 12/10/2024. A review of facility policy titled, Dental Services, effective 11/4/24, revealed, Policy: The facility will provide, or obtain from an outside resource, routine and twenty-four [24] hour emergency dental services to meet the needs of the resident and also when requested by the resident . Emergency dental services includes services needed to treat an episode of acute pain in teeth gums, or palate; broken or otherwise damaged teeth; or any problem of the oral cavity that requires immediate attention by a dentist . E. Progress notes from the service provider are to be obtained and placed in the resident's medical record. F. The resident's physician, family and/or resident representative should be informed of the results of the service and any recommendations should be reviewed with the physician .H. Follow up visits will be scheduled as needed.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 Based on observation, interview and record review, the facility failed to ensure adaptive equipment was provided for meals and hydration for one resident (Resident #14), of one resident reviewed for adaptive equipment during meals, resulting in frustration with attempting to feed self, spilling water from Styrofoam cup and the potential for weight loss and dehydration. Findings include: Resident #14: A review of Resident #14's medical record revealed an admission into the facility on [DATE] and re-admission on 7/8/24 with diagnoses that included depression, contractures of right and left lower legs, aphasia, dysphagia, muscle weakness, adult failure to thrive, and need for assistance with personal care. A review of the Minimum Data Set assessment dated [DATE], revealed the Resident had moderately impaired cognition and needed set-up or clean-up assistance with eating and was dependent on staff for oral hygiene, toileting hygiene, bathing, dressing, personal hygiene and mobility and transfers. On 1/30/25 at 9:08 AM, an observation was made of Resident #14 in bed with the head of the bed raised. The Resident had the overbed table positioned near her. She had a Styrofoam cup that was on its side and a straw in the bed with her. The table was wet and there was water on the floor next to the bed and under the bed. The Resident reported she had spilled the water when she was trying to get a drink. The Resident was interviewed, answered questions but engaged in limited conversation. Staff came in to give the Resident her breakfast tray and wiped up the water next to the bed and on the table. Another staff came in and the resident was boosted up in bed to eat and the staff left the room with the Resident set up with her meal tray while in bed. An observation was made of a juice sized cup that was filled almost to the top and did not have a lid on it. The Resident was trying to pick up her utensils but was having a hard time getting the fork off the tray. An observation was made of poor hand control and the Resident expressed frustration. The Resident was asked if she could manage the cup of juice and the Resident reported she would spill it. An observation was made of a meal ticket on the tray that stated, Adaptive Equip (equipment): 2-Handled Spouted Cup, built-Up Utensils On 1/30/25 at 9:13 AM, during the interview, the Resident did not eat, and staff did not return with adaptive equipment as listed on the Resident's meal ticket. Nurse U was found and was asked about the adaptive equipment. The Nurse stated, She should have it on there, the built-up utensils and spouted two handled cup. The Nurse checked to see if dietary staff were still present in the dining area, and they were gone. She had retrieved a spouted two handled cup from a beverage area by the nurse's station for the Resident. The Nurse went down to dietary and retrieved the built-up utensils. On 1/30/25 at 2:40 PM, an interview was conducted with the Dietary Manager (DM) H regarding the adaptive equipment for Resident #14's meals. The DM reported that they did have the adaptive equipment available, and the Resident should have it for every meal. The DM indicated that the built-up utensils were to be placed on the tray by the dietary staff and the two handled cups were available on the coffee cart where the CNA's (Certified Nursing Assistant) would put the liquids into the cups. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/25 at 12:10 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #14's lack of receiving the adaptive equipment during the Resident's meal. The observation of a Styrofoam cup at the Resident's bedside was reviewed and the Resident spilling her water. When asked if the Resident was to get a two handled cup for the water pass for hydration, the DON stated, That would make sense. A review of Resident #14's care plan for a Focus for functional ability deficit and requires assistance with self care/mobility . with an Intervention for Eating: Limited 1 PA (physical assist), 2 handled cup with lid, built up utensils. A review of Resident #14's documents titled, Therapy Communication Care Plan from to Nursing/MDS, dated [DATE] and signed by Therapist, revealed, .Feeding Max A (assist) -2 handled cup with lid and straw, -built up utensils .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation and interview the facility failed to maintain sanitary conditions in the kitchen, resulting in an increased potential for cross contamination of food, foodborne illness and improper kitchen sanitization, potentially affecting all residents who consume meals from the kitchen. Findings Include: On [DATE] at approximately 10:00 AM, a tour of the kitchen was started with Assistant Administrator Q and concluded with Dietary Manager AA upon entering the kitchen, dietary staff were actively cleaning out the walk-in cooler. The following expired and/or unsanitary conditions were observed during the tour: Walk-in Cooler: -Floors had spills in different areas of what appeared to milk, and the floor was sticky in some areas. -There were miscellaneous items strewn across the floors such as lids and onion peelings. -18 cups of orange juice inside an extended white tray- some of the juices lids were off and there was spilled juice in the bottom of the tray. It was dated [DATE]. -1 gallon of jalapenos with expiration date of [DATE] -Both fan covers in the walk-in cooler were riddled with build on dirt and debris. The fans itself also were observed with grayish particles on the fan blades. The encapsule containing the fans had unknown dust/debris/particle buildup around the perimeter. Maintenance Director BB reported it was unknown the last time the fans in the cooler or freezer were cleaned but he would provide the logs for it. Walk-in Freezer: -10-pound ham with no expiration date -Small container of purer meat- expired [DATE] -,d+[DATE] pounds of Spaetzle Dumplings- no expiration date -5-pound bag of Pepperoni- expired [DATE] -7- biscuits in unsealed bag with no expiration date -5-pound hamburger - with no expiration date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-3- pound bag of chicken with no open/use by date -Both fan covers were riddled with build on dirt and debris. The fans itself also were observed with grayish particles on the fan blades. Dry Storage: -18- Evaporated milk cans- expired ,d+[DATE] -20 pack or tortillas- expired [DATE] -1 box- pasta- expired [DATE] -35 oz box of raisins - expired [DATE] 35 oz container of Frosted Flakes- no use by date. Manager AA reported those items should have been discarded and she's unsure how they were missed in her walkthroughs. Kitchen Area: -Underneath both pop machine spigots was a black/brown dried substance and other unknown splattered substance. -Underneath pop machine was a dried brown substance that was circular in shape -Inside individual toaster was brown/blackened particles at the bottom. -20-pound container of thickener expired [DATE] -20-pound container of sugar expired on [DATE] Dishwashing Area: The top of dishwasher had observable debris in multiple areas and the entrance to the dishwasher had a white/beige clumpy build up around the edges. Manager AA reported it appeared to be calcium build up, but she was not 100% certain. Manager AA was asked to run a test strip to verify if the appropriate temperature was reached for sanitization. As the 1st cycle was completing the wash temperature was at 140 and 3rd cycle- wash temperature at 140 and rinse temperature at 180 . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:30 AM, an interview was conducted with Dietary Manager AA regarding the kitchen tour. The manager reported she started in [DATE] and is working toward maintaining structure within the kitchen. Review was completed of the kitchen cleaning logs with many of the daily tasks being blank. She explained they are cleaning in the kitchen but have not initialed them. Manager AA stated cleaning atop the dishwasher and the white buildup observed at the entrance of the machine, is not on the cleaning log so it's nothing they would complete. When asked if she could provide cleaning logs from the prior month, she stated they would be incomplete like the current ones. Everything that was found in the cooler and freezer should have at least had an open date at the very least. Review was completed of the cleaning log from [DATE] to [DATE] and it showed of the four pages of tasks they rarely were completed daily. The log was 85% blank. Review was completed of the facility policy entitled, Use by Date Storage Chart, revised ,d+[DATE]. It stated, All unopened prepackaged processed products should be used or discarded by the Manufacturers expiration date .Meat and poultry - 30 days in freezer .Hard sausage- pepperoni slices-6 months in freezer . Review was completed of the facility policy entitled, Dish Machine Usage and Sanitation, revised [DATE]. The policy stated, .the dish machine will be cleaned inside and out after each meal. Dish Machine will be de-limed, as needed .Minimum wash temperature ,d+[DATE] . final rise temperature must be at least 180 F.

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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** 37666 Based on observation, interview and record review, the facility failed to ensure Infection Prevention and Control standards of practice were followed for 1). Safe handling of ice and 2). Proper storage of personal items to prevent contamination, resulting in the potential for spread of infection, which could cause serious illness. Findings Include: FACILITY Infection Control On 1/31/2025 at 1:10 PM an Activity Aide entered the facility elevator carrying 2 large basins stacked on top of each other; each basin was filled with ice. Neither basin was covered, and the ice was open to the air with the aide's body leaning against the basins. The aide was asked what was in the basins and she stated, It's ice for daquiris. The aide exited the elevator and walked in to the resident activity area. On 1/31/2025 at 1:20 PM, Infection Prevention and Control/IPC Nurse A was interviewed related to the observation of an activity aide entering the elevator with 2 large uncovered basins each filled with ice. The IPC Nurse A said the facility had covered pitchers that were used to transport ice, and the aide should have used those. A review of the Centers for Disease Control and Prevention/CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in all Settings, dated April 12, 2024 provided, Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings where healthcare is delivered . 37771 Room Observations room [ROOM NUMBER]/318 On 1/29/25 at 10:31 AM, an observation was made in the bathroom between rooms [ROOM NUMBERS] of a urinal that was dirty around the rim and had residual urine in the container. The urinal had a date of 1/17/25 but did not have a name or resident identification on it. There was a bedpan that was not in a bag but positioned in the handrail by the toilet. The bedpan did not have any resident identification on it to identify which resident the bedpan belonged. There were four Residents that shared the bathroom. room [ROOM NUMBER] (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 11:09 AM, an observation was made of room [ROOM NUMBER]. The Resident in bed 2 had a bedpan that was positioned on the bedside table upside down and laying on top of personal items that included food items. room [ROOM NUMBER] On 1/29/25 at 11:17 AM, an observation was made of room [ROOM NUMBER] that had four residents residing in the room. An observation was made of a urinal in the bathroom that had residual urine in the bottom. The urinal did not have a name or room number to identify who the urinal belonged to. The Resident in bed 4 reported he did not know who the urinal belonged to and indicated he had one at the bedside. The urinal did not have a name or identification on it. The Resident reported the urinal had been in the sink and he removed it and set it aside. room [ROOM NUMBER] On 1/29/25 at 12:12 PM, an observation was made of room [ROOM NUMBER]. There was a sink in the room. An observation was made of toothpaste and a toothbrush stored next to the sink underneath the towel dispenser and there is a denture cup with no lid positioned in the same area beneath the soap dispenser and towel dispenser. There is no name on the denture cup and a top was not in the vicinity. The two residents that share the room were not in the room at the time. On 1/30/25 at 9:02 AM, an observation was made in room [ROOM NUMBER]. The Residents were eating breakfast in the room. An observation was made of the sink in the room that had the toothbrush wrapped in a paper towel positioned under the towel dispenser and the denture cup that had water and dentures inside the cup. There was no lid on the denture cup and the cup was positioned underneath the soap dispenser. room [ROOM NUMBER] On 1/29/25 at 1:15 PM, an observation was made of room [ROOM NUMBER] that had four residents residing in the room. A urinal was in the bathroom, appeared to be used. The urinal had no identification or which resident it belonged to. On 1/31/25 at 12:22 PM, an interview was conducted with the Director of Nursing (DON) regarding the storage of personal items such as urinals and bedpans. The DON was asked if the items needed to have identification to which resident the items belonged to. The DON indicated that they should be marked with identification. The DON was informed of the bedpan over the personal items and food items and reported they will take care of that.