STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235356	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge at the Shore	900 S Beacon Blvd Grand Haven, MI 49417

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on interview and record review, the facility failed to accurately assess/implement advanced directives (upon admission) for 2 Residents (R102 and R110) of 4 Residents reviewed for advanced directives. Findings include: R102 Review of R102's face sheet dated 9/18/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: congestive heart failure, dysphagia, pharyngeal phase (swallowing problem), cognitive communication deficit, unsteady on feet, muscle weakness, Alzheimer's disease, difficulty in walking and abnormal posture. R102 was not her own responsible party. Review of R102's electronic medical record revealed no signed copy of R102's advanced directive. During an interview with the Director of Nursing on 9/17/24 at 11:40 AM, the DON said the nurses complete the advanced directives on admission. The DON said R102's son was her Durable Power of Attorney. The DON could not find any information that validated R102's son was contacted about R102's advanced directives. On 9/17/24 at 11:47 AM, the DON had an advanced directive form for R102 dated today 9/17/24 that was signed by R102. The DON was not able to locate an advanced directive completed by R102's son. The DON confirmed that R102 was not her own responsible party, and she was not able to locate any information that R102's son had been contacted to complete R102's advanced directive. Review of R102's advanced directive dated 9/17/24 revealed that the box for I do not choose to formulate or issue any Advanced Directive at this point was marked. It was signed by R102 (R102 was not her own responsible party, see the face sheet). After the Facility Representative/Title it was signed by the facility social worker. R110 (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R110 face sheet dated 9/16/24 revealed she was a [AGE] year-old female admitted on [DATE] and had diagnoses that included: acute respiratory failure, sepsis, pneumonia, diabetes mellitus 2, dysphagia (swallowing problems) and cognitive communication deficit. R110 was listed as her own clinical responsible party. Record review reveal no advanced directive on record for R110. During an interview with the DON on 9/17/24 at 10:30 AM the DON said they had identified issues with the nurses not completing new admission advanced directives. During an interview with the facility Social Worker (SW) N on 9/17/24 at 10:35 AM, SW N confirmed that R110 was still her own responsibility party and R110's husband had not provided the facility with a Durable Power of Attorney (DPOA) papers. During an interview with the Director of Nursing on 9/17/24 at 11:40 AM, the DON had located an advanced directive for R110 dated 8/29/24 that was signed by R110's husband. The DON said R110 is her own responsibility party and should have signed her own advanced directive. Review of R110's Advanced Directive revealed the box for I do not choose to formulate or issue any Advanced Directive at this time was marked. After resident signature was the husbands, signature dated 8/29/24.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to ensure: 1) that a Pre-Admission Screening and Resident Review (PASARR) Level I was completed timely for the annual review and 2) that the PASARR Level II was completed for 1 of 2 residents (R71) reviewed. Findings include: A review of R71's Admission Record, dated 9/16/24, revealed R71 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 71's Admission Record revealed multiple diagnoses that included dementia, depression, anxiety, and schizophrenia. A review of R71's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 6/7/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 1 which revealed R71 was severely cognitively impaired. A review of R71's [name of State] Department of Health and Human Services letter, dated 7/14//23, revealed R71 needed a PASARR II Evaluation by 7/12/24. A review of R71's electronic medical record, dated 10/1/23 to 9/16/24, revealed the following: - PASARR Level I Screening, dated 8/12/24, revealed R71 required a PASARR Level II Evaluation (a comprehensive evaluation that is conducted to confirm or rule out a serious mental illness, intellectual disability, or related conditions and determine the need for nursing facility services). - No PASARR Level II Evaluation for 2024 was in the medical record. During an interview on 09/17/24 at 03:45 PM, Social Worker (SW) A stated she does not e-mail the OBRA (Omnibus Budget Reconciliation Act) Coordinator (the third party individual responsible for conducting the PASARR Level II Evaluation) to let them know when a PASARR Level I Screening was completed and that a resident requires a Level II Evaluation. She stated, I just put it in the system and does not do anything further. She stated she assumes the OBRA Coordinator sees the PASARR Level I Screening when she puts it in the system and they see that the resident needs a Level II Evaluation. However, SW A did not know for sure when the OBRA Coordinator received R71's PASARR Level I Screening and if they noticed that R71 needed a Level II Evaluation. She also stated she does not know when R71's PASARR Level II Evaluation will be completed because she has not heard from the OBRA Coordinator. SW A further stated she would e-mail the OBRA Coordinator today and ask them when R71's Level II Evaluation will be completed. The surveyor requested a copy of the e-mail that R71 sends to the OBRA Coordinator with their reply as to when they received R71's Level I Evaluation and when they plan to complete the Level II Evaluation. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/17/24 at 04:00 PM, the Director of Nursing (DON) stated she agreed that R71's PASARR Level II Evaluation was late. She stated the SW A should have heard from the OBRA Coordinator by now on when he was planning on completing R71's Level II Evaluation (the Level I Screening was completed on 8/14/24- one month prior to the interview). The DON further stated the SW A should have followed up with the OBRA Coordinator to see if he received the PASARR Level I Screening and when he was planning on completing the PASARR II Evaluation, especially since she had not heard from him in over 30 days. She stated it did not seem that the SW A had a system for submitting and following up with PASARR Level II Evaluations. During a second interview on 09/18/24 at 08:20 AM, The DON stated that she had an e-mail from the OBRA Coordinator that was sent to SW A on 7/8/24 notifying her (SW A) that R71's PASARR Level I Screening needed to be completed. She stated it appeared that the OBRA Coordinator had a system for tracking PASARR Level I Screenings and SW A did not. The DON verbally agreed that SW A should have a system for tracking PASARR Level I Screenings and should not depend on the OBRA Coordinator to notify her when they need to be completed. She also stated that the OBRA Coordinator instructed the SW A on where she could find the information in the system that he received PASARR Level I Screenings and where she can see that the Level II, if applicable, was scheduled and/or pending completion. The DON stated currently R71's PASARR Level II Evaluation was pending and did not have a scheduled time for completion. She stated she was hoping it would be completed soon since it was currently two months overdue according to the [name of State] Department of Health and Human Services letter, dated 7/14//23 (see above). A review of the e-mail from the OBRA Coordinator, dated 7/8/24, did not indicate when they (the OBRA Coordinator) had contacted SW A regarding R71 needing her annual PASARR Level I Screening. However, the e-mail was a reply from SW A to the OBRA Coordinator and in it SW A had indicated she would complete R71's PASARR Level I Screening (the 77- DCH (Department of Community Health) 3877 form) today (7/8/24). However, according to R71's PASARR Level I Screening, dated 8/12/24, it was not completed until 35 days later (31 days past the due date).

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations interview and record review the facility failed to follow the care plan for 1 Resident (R465) for assistance with eating. Findings included: Review of R465's face sheet dated 9/17/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and diagnoses included kidney failure, dementia, macular degeneration (visual problem), dysphagia (swallowing problem) and cognitive communication deficit. R465 was not his own responsible party. Review of R465's activities of daily living care plan dated 9/11/24 revealed that he required assistance of one person for eating. R465 was observed on 9/17/24 at 12:05 PM eating lunch. No staff in room, resident was requesting cold water but did not know how to put on the call light. CNA L came in the room at 12:10 PM and left again attempting to get R465 thickened cold water. R465 still had his meal tray in front of him when CNA L left the room. R465 was observed up in his wheelchair in his room on 4/18/24 at 8:08 AM eating breakfast. No staff in the room. During an interview with RD J on 9/18/24 at 8:38 AM, RD J was informed of the observations of R465 eating independently in his room. RD J confirmed R465 was on a puree diet and thickened fluids and was being treated by Speech therapy for his swallowing problems. A request for the Speech therapy recommendation for feeding was made. R465 was observed alone in his room eating breakfast on 9/18/24 at 9:29 AM. Review of R465's Speech Therapy Progress note dated 9/16/24 revealed, Pt (patient) continues to present with impaired cognitive-communication functioning that negatively impacts the patient's ability to safely complete ADLs (Activities of Daily Living) and to communicate wants/needs/preferences for care. Also, pt (patient) with dysphagia (difficulty swallowing) and impaired swallowing functioning that negatively impacts pt's (patients) ability to meet basic nutrition and hydration needs with a regular-textured and thin liquid diet safely and independently.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record review, the facility failed to provide adequate supervision, conduct timely root cause analysis of fall incidents, implement appropriate interventions to prevent future falls and re-evaluate the effectiveness of interventions for 3 residents (R48, R102, and R456) out of 3 residents reviewed for falls, resulting in R48 falling and sustained a wrist fracture and R102 fell and sustained a laceration requiring emergency room treatment. Findings included: R48 Review of R48's face sheet dated 9/18/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: Bipolar Disorder, epilepsy (seizure disorder), muscle weakness and diseases of intestine. R48 was listed as her own responsible party. Review of R48's care plan date initiated 2/20/24 and revision on 9/17/24 revealed, Resident has behavior (s) related to (SPECIFY: diagnosis/reason) as evidenced by makes accusatory statement, medication seeking, physically aggressive toward staff, refuses treatments, resistant to care, sexually inappropriate toward staff, throwing objects, Destruction and damaging property, Threatening or intimidating comments, removal of medical necessary devices. Transfers and ambulates independently when she is aware she needs assist. Review of R48's care plan date initiated 2/7/24 and revision on 9/17/24. Resident is at risk for falls/injury related to impaired mobility, weakness, chronic pain, incontinence, morbid obesity, epilepsy, osteoporosis, psychotropic med use, opioid pain medication. Transfers self and ambulates independently without asking for assist. Interventions included: anti-roll back to w/c (wheelchair) 9/12/24, Educate family on resident's safety interventions, 9/17/24, Educate resident and family to call for assistance before transferring, dated 9/19/24, Educate on safety interventions, dated 2/7/24, Encourage resident to keep needed items within reach, dated 2/7/24, Encourage resident to keep walker within reach, dated 9/17/24, Encourage resident to keep wheelchair accessible within reach, 9/17/24, monitor resident's position to reduce the risk of sliding/falling, dated 9/17/24, non-skid footwear to reduce the risk of slipping as the resident allows, dated 9/12/24, Keep bed at a safe transfer height. Disabling bed control so height can not be adjusted so residents bed will remain at the safe height at all times, dated 9/12/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R48 was observed on 9/18/24 at 12:10 PM partially sitting on the edge of her bed. Resident (R48's) feet were on the floor (no shoes or socks on her feet). Resident (R48's) bed height appeared to be in the highest position. (higher than the surveyor waist and resident was not able to fully sit back on the mattress with her feet on the floor). R48 had her lunch tray in front of her and her curtain was pulled so she could not see her roommate. No staff in the room. R48 was not able to recall the last time she fell or any details of the fall that resulted in her wrist fracture. When the resident could not recall the answers, her roommate said she had fallen twice last week and said R48 does not remember to put on her call light. The roommate said she tries to put on the call light when she is aware R48 is walking independently. R48's roommate was very concerned about the falls last week because she thought she broke her hand. R48 confirmed that her left hand was sore and was not upset with her roommate answering questions for her. R48 did not deny any of the information her roommate provided. R48 denied knowing anything she should be doing differently to stay safe. Review of R48's incident and accident reports revealed she had 4 falls between 5/29/24 and 9/12/24. Review of R48's incident and accident report dated 5/29/24 at 3:25 AM revealed R48 was using the bathroom while the Certified Nurse Aide (CNA) was making her bed. R48 stood up using her walker independently, lost her balance and sat on the floor. Review of R48's Fall Assessment for R48's fall effective date of 5/29/24 at 3:36 AM revealed the only new care plan intervention was, Bed height adjustment. No investigation/witness statements or root cause analysis was located. Review of R48's incident and accident report dated 7/3/24 at 18:26 (6:26 PM) revealed R48 had an un-witnessed fall in her room. When the nurse entered her room, she was found laying on her stomach near her bed. R48 was barefoot, she was not using her walker, call light was on the bed but not in use. R48 said she came out of the bathroom because her phone rang. Bathroom call light was not on. Under Injuries Report Post Incident, Fracture Right Wrist. Review of R48's Fall Assessment for effective date 7/3/24 at 18:38 (6:38 PM) revealed no investigation or witness statements, no root cause analysis. The only new intervention listed was, change in footwear. Review of R48's progress note dated effective 7/3/24 at 18:38 revealed, the same fall information as the incident and accident report with the additional information the nurse received a telephone call from the emergency room reporting R48 had a right wrist fracture. Review of R48's incident and accident report for 9/11/24 at 7:40 AM revealed R48 was witnessed dropping to the floor onto her buttock while walking to her bed with her walker. R48 said she was trying to sit on her bed, but the bed was too high, and she dropped to the floor. A staff witness statement revealed, I was behind the resident, supporting her buttock, when she dropped suddenly to the floor, having tried to sit on her bed which was raised too high by the resident prior to ambulating to the bathroom independently. Review of R48's Fall Assessment for effective date 9/11/24 at 19:00 (7:00 PM) revealed no investigation or root cause analysis. The only new intervention listed was, bed height adjustment. (see observation 9/18/24 at 12:10 PM, R48 sitting on the edge of her bed, bed in high position, no staff in her room). This intervention was not implemented. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R48's incident and accident report dated 9/12/24 at 00:50 (12:50 AM) revealed R48 self-transferred from her walker to her wheelchair in her room. The wheelchair was not locked, and the resident tried to lock the wheelchair, but the wheelchair slipped and she fell to the floor. Under injuries observed at the time of the incident revealed, strain, right wrist. Under predisposing physiological factors, the boxes for confused, drowsy recent change in medication/new medications, sedated, gait imbalance, and weakness/fainted were all marked. Under predisposing situation factors the following boxes were marked, during transfer, improper footwear, using walker, using wheeled walker. No witness statements or investigation was found. Review of R48's Fall Assessment for effective date 9/12/24 at 1:23 AM revealed, no investigation or root cause. The only new intervention listed was change in footwear (see previous falls this was also an intervention). Change in footwear describe box listed, Must wear non-skid footwear. Review of an Interdisciplinary Team note for R48 dated 9/18/24 at 13:30 PM, for and effective date of 9/12/24 at 9:53 AM revealed the interdisciplinary team discussed R48's incident form 9/11/24. R48 often transfers and walks independently even though she needs assistance from staff. R48 frequently raises her bed to an unsafe high level. The root cause was identified to be R48 raising her bed to an unsafe level and then transferring independently. The new intervention was to have maintenance disable the up/down controls on the bed at a safe transfer level so when R48 self-transfers it will be safer. (See observation on 9/19/24 this intervention was not implemented). Root cause was completed during the survey process, 7 days post fall. Review of R48's Interdisciplinary Team note dated 9/18/24 at 13:34 (1:34 PM) for effective date 9/12/24 at 10:02 AM (meeting held during the survey) revealed the team discuss an incident that occurred on 9/12/24 where R48 was found on the floor. There was no mention of her confusion, drowsiness, medication changes, gait imbalance, sedation or weakness that were listed as predisposing physiological factors. The IDT team identified the root cause as the wheelchair not being locked. The new interventions identified were anti-lock brakes and non-skid footwear. On 9/17/24 at 11:11 AM the Director of Nursing (DON) provided 2 of R48's fall incident and accident reports and post fall assessment. The DON was asked again if these were all the fall reports and full investigations. The DON said the facility had identified a few weeks ago that they were not compliant with fall regulations and were currently in the process getting into compliance with falls. The DON was asked to briefly describe the issues they identified and the DON said it was the follow up information related to the falls and the root causes. Review of the facility Fall Policy dated 11/2/23 revealed, 8. For an individual who has fallen, staff should attempt to define possible causes within 24 hours of the fall. 9. Post fall analysis items to be considered. The A/I (accident incident), the nurses notes, review for med changes in the last 30-90 days, review for previous lab findings, review for acute changes, review staff and witness statements (to include last time resident seen, provided care and what type of care), Review of care plan and CNA (certified nurse aide) assignments/Kardex that were in place at the time of the fall, observe any equipment involved (i.e. wheelchair, bed, commode, shower chair, etc.), observation of the resident's room or area of the fall, reenactment. 10. Analysis of the causative factors and rationale for interventions developed and implemented should be documented in the Standards of Care notes. R102 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R102's face sheet dated 9/18/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: congestive heart failure, dysphagia, pharyngeal phase (swallowing problem), cognitive communication deficit, unsteady on feet, muscle weakness, Alzheimer's disease, difficulty in walking and abnormal posture. R102 was not her own responsible party. Review of R102's falls care plan dated 3/17/24 with no revision date revealed R102 was at risk for falls related to bladder incontinence, decreased strength and endurance, functional problems and generalized weakness. The interventions included wheelchair anti-rollback dated 9/10/24 and place reminder to call signs in bathroom and resident area to room dated 9/10/24. Grip strips to floor next to bed dated 7/12/24, keep wheelchair locked at bedside when in bed dated 7/12/24, educate resident and family to call for assistance before transferring dated 3/17/24, educate on transfer and ambulation techniques as resident allows dated 9/16/24, encourage resident to keep needed items within reach dated 9/16/24, encourage resident to keep wheelchair in reach dated 9/16/24, non-skid footwear to reduce the risk of slipping as the resident allows, place call light in reach dated 9/16/24. (most of the interventions were placed during the survey, the inventions did not address the resident's memory deficits, history of falls and unsafe transfers, no interventions were located to determine how the facility was providing supervision due known safety issues and impaired cognition). R102 was observed on 9/18/24 at 12:20 PM eating lunch at a bedside table. The table was facing the room outside wall. R102 had no idea how long she had been here and no recall of any falls. There were no staff and no roommate in the room at that time. Review of R102's incident and accident reports revealed she had 4 falls between 3/26/24 and 9/9/24. Review of R102's incident and accident report dated 3/26/24 at 19:47 (7:47 PM) revealed she had an unwitnessed fall in her room. Her roommate witnessed the fall and reported she was waling towards her closet when she was about to sit in her wheelchair, the wheelchair wasn't locked she slid off. Predisposing psychological factors indicated R102 was confused. Predisposing situation indicated R102 was ambulating without assist. No staff witness statements were found, no investigation, no indication of previous care or condition prior to the fall was located. Review of R102's Fall Assessment for effective date 3/26/24 at 20:02 (9:02 PM) revealed. R102 was toileted at 18:00 (6:00 PM) and was in bed prior to the fall. No investigation of this event was located. Review of R102's incident and accident report dated 4/10/24 at 14:10 (2:10 PM) revealed R102 had a witnessed fall and was attempting to sit on her walker but forgot to lock the brakes. Predisposing Physiological Factors on the fall incident report indicated, gait imbalance, recent change in cognition, weakness/fainted. No statement or names of witnesses were located. Review of R102's Fall Assessment for effective date 4/10/24 at 14:36 (2:36 PM) revealed R102 was toileted at 14:00 (2:00 PM) 10 minutes before (R102) fell . The box for other was marked on new care plan interventions (no note for what this meant was located on this form). No witness names or statements were listed. No root cause was located. No interdisciplinary note was provided. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R102's incident and accident report dated 7/12/24 at 5:25 AM revealed she had an unwitnessed fall. She was found lying on the floor in her room on her left side. R102 said she fell walking to the bathroom. R102 had a laceration above her right eye actively bleeding. Under mental status was noted, Resident remained on the floor until EMS (emergency medical services) arrival. Resident transferred to stretcher via EMS and taken to ER (emergency room) for evaluation and treatment. Injury listed laceration to face. Predisposing Physiological Factors marked impaired memory. Predisposing Situation Factors marked ambulating without assistance and improper footwear. No statements, investigation or documentation of R102 condition prior to the fall were located. R102's Fall assessment dated effective 7/12/24 at 5:38 AM revealed they received physician orders to send R102 to the emergency room . R102 was toileted at 3:00 AM (2 hours and 25 minutes prior to finding her on the floor. New intervention listed as other. No witness or witness statements were located, no other information about R102's condition prior to the fall was located. No root cause analysis or interdisciplinary notes were provided. Review of R102's incident and accident report for 9/9/24 at 12:41 PM revealed the nurse heard R102's roommate call out and when she entered R102 was sitting on the floor on her bottom in the bathroom with the back of her head leaning on the wall. R102 had appropriate footwear with nonskid sole. R102 did not use the call light or indicate a need for help. R102 said she was attempting to use the bathroom. Predisposing Physiological Factors marked gait imbalance and impaired memory. Predisposing situation factors marked ambulating without assist. Under statement listed a resident name, Resident reported that R102 had entered the bathroom and stated she was going to wash her hands, resident then attempted to stand up and fell . Immediate action taken was, placed sign to use call light to help prevent self-transferring place in bathroom (R102 was cognitively impaired and there was no indication she could read posted signs) and resident room. Requested anti roll back for wheelchair. Review of R102's Fall Assessment effective date 9/9/24 at 12:42 PM revealed she was toileted at 11:30 AM (a little over 1 hour prior to the fall). New intervention marked other. Review of R102's Interdisciplinary note effective date 9/10/24 at 9:52 AM revealed the team discussed R102's fall that occurred on 9/9/24. Resident has poor gait and needs assistance with transfers and ambulation. Resident also has poor cognition and forgets to lock her breaks and ask for assistance. Root cause identified as resident attempting to transfer without assistance. New intervention for call light reminder signs in both her bathroom and her bedroom and request for anti-roll back device. There was no indication of how the facility planned to assess or increase her supervision or notes for her previous falls with injuries. Similar/Identical interventions were not successful at preventing unsafe transfers/ambulation. There was no indication of ongoing assessment for effectiveness of interventions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Fall Policy dated reviewed 11/2/23 revealed, 8. For an individual who has fallen, staff should attempt to define possible causes within 24 hours of the fall. 9. Post fall analysis items to be considered. The A/I (accident incident), the nurses notes, review for med changes in the last 30-90 days, review for previous lab findings, review for acute changes, review staff and witness statements (to include last time resident seen, provided care and what type of care), Review of care plan and CNA (certified nurse aide) assignments/Kardex that were in place at the time of the fall, observe any equipment involved (i.e. wheelchair, bed, commode, shower chair, etc.), observation of the resident's room or area of the fall, reenactment. 10. Analysis of the causative factors and rationale for interventions developed and implemented should be documented in the Standards of Care notes. R465 Review of R465's face sheet dated 9/17/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and diagnoses included kidney failure, dementia, macular degeneration (visual problem), dysphagia (swallowing problem) and cognitive communication deficit. R465 was not his own responsible party. Review of R465's activities of daily living care plan dated 9/11/24 revealed that he could not walk, he required assistance of one person for bed mobility, dressing, eating, hygiene, toileting, transfers, he needed encouragement to use his call light for assistance. Review of R465's fall care plan dated 9/11/24 revealed he was at risk for falls related to dementia, OA (osteoarthritis) macular degeneration (visual problems), CHF (congestive heart failure), HTN (hypertension), DDD (degenerative disc disease) compression fracture, edema (swelling). Interventions listed: foot pedals to be removed form wheelchair unless being propelled. Educated resident on safety interventions, encourage resident to keep needed items within reach, encourage resident to use call light, ensure resident's room is free from accident hazards (e.g., providing adequate lighting (not in place on 9/16/24 see incident and accident report), ensuring there are no trip hazards, providing assistive devices), PT/OT/SLP (physical therapy, occupational therapy, speech language pathology). No interventions for supervision were located. Review of R465's incident and accident report dated 9/13/24 at 14:38 (2:38 PM) revealed he had an un-witnessed fall. He was found sitting on the floor on his foot pedals of his wheelchair. Predisposing environmental factor marked poor lighting. Predisposing physiological factors marked admitted within last 72 hours. One staff statement was listed, I found the resident sitting on his wheelchair legs when I walked into the room. There was no information located as to who had provided care or what time last care was provided. No interdisciplinary note or root cause analysis was located. No new interventions were located. R465 was observed in bed awake on 9/16/24 at 9:23 AM. R465 wanted water but did not know how to use his call light. Resident was assisted by the Surveyor to put on his light as staff were not in the room. R465 was observed on 9/17/24 at 12:05 PM eating lunch. No staff in room and resident was requesting cold water but did not know how to put on the call light. Staff came in the room at 12:10 PM and left again attempting to get R465 thickened cold water. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R465 was observed alone in his room eating breakfast on 9/18/24 at 9:29 AM. R465 was not aware of where he was and asked 5 times in approximately 5 minutes how the weather was outside today. R465 did not recall falling in the facility or recall how long he had been here.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview, and record review, the facility failed to adequately assess one resident (R465) for hydration and food intake of 1 Resident reviewed for nutrition. Findings included: Review of R465's face sheet dated 9/17/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and diagnoses included kidney failure, dementia, macular degeneration (visual problem), dysphagia (swallowing problem) and cognitive communication deficit. R465 was not his own responsible party. Review of R465's activities of daily living care plan dated 9/11/24 revealed that he required assistance of one person for eating. R465 was observed in bed awake on 9/16/24 at 9:23 AM. R465 wanted water but did not know how to use his call light. R465 did not have any drinks in his room. Resident was assisted by the Surveyor to put his light on as staff were not in the room. Certified Nurse Aide (CNA) L responded. R465 told CNA L he wanted cold water. CNA L returned to the room without any drinks. CNA L said R465 was on thickened liquids and the kitchen was currently out of cold thickened water. CNA L said water pass was at 7:00 AM, he did not recall if R465 had water at that time but said he did eat breakfast and had fluids with breakfast. R465 was observed on 9/17/24 at 12:05 PM eating lunch. No staff in room and resident was requesting cold water but did not know how to put on the call light. CNA L came in the room at 12:10 PM and left again attempting to get R465 thickened cold water. CNA L returned the room and reported the kitchen was out of cold thickened water. CNA L had cold thickened milk and R465 told him he does not drink milk. R465 again requested cold water or Pepsi. CNA L said the facility did not have Pepsi. During an interview with Registered Dietitian (RD) K on 9/17/24 at 12:20 PM the surveyor expressed concern about the facility not being able to provide cold thickened water for R465 on 9/16/24 and again at lunch today (9/17/24). RD K was able to locate cold thickened water and took it to R465. However, R465 wanted thin ice water and would not drink the thickened cold water. RD K also obtained a cold Pepsi and had it thickened. R465 did takes sips of the thickened Pepsi and requested thin Pepsi on ice. RD K explained he need thickened liquids due to his swallowing problems. Review of R465's fluid intake record revealed R465 had a fluid intake of 480 ounces on 9/17/24 at 8:40 AM. During an interview with CNA L on 9/17/24 at 1:20 PM, CNA L was asked about the amount of fluid R465 had that morning. CNA L said R465 drank his thickened orange juice and it was 120 ounces. He denied R465 had any other fluids that morning. The Surveyor questioned the 480 ounces that was recorded for 9/17/24 at 8:40 AM and CNA L said he was not able to get into the electronic documentation system and another CNA recorded that amount. CNA L was not able to recall the staff person that entered the 480 ounces of intake for 9/17/24 at 8:40 AM. The record review did not include the identification of the staff entering the information. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) and CNA J on 9/17/24 at 1:25 PM. CNA J confirmed that she documented the 480 ounces of intake for R465 on 9/17/24 at 8:40 AM because CNA L was not able to get into the electronic system. CNA J said R465 had drank one large cup of something (she did not observe any intake just an empty cup). CNA J said the large drinking cups on the trays were 480 ounces. The DON corrected her and informed her they were 240 ounces. CNA J said she should have recorded 240 ounces. The DON was informed CNA L said R465 only drank 120 ounces of thickened orange juice that morning. The Surveyor expressed concern over the discrepancy of observations, interviews and record review of R465's fluid intake. The DON did not provide any additional information about the intake discrepancy upon exit. R465 was observed up in his wheelchair in his room on 9/18/24 at 8:08 AM eating breakfast. No staff in the room. R465 only took a few bites of the two scoops of food on his tray and did not eat any of the food in the bowl. R465 was sipping on thickened orange juice. CNA J came in the room at 8:25 AM. R465 also had an untouched cup of thickened milk on his tray. CNA J confirmed the empty cup she observed the morning of 9/17/24 and recorded at 8:40 AM was the 240-ounce cup not 480 ounces. CNA J said she just learned R465 did not like milk. On 4/18/24 at 8:28 AM, CNA H removed R465's. When CNA H was in the hall the surveyor asked if CNA H was going to record R465's food intake for this tray. CNA H said she was. When asked what she was going to record she said, 300 ounces of fluid and 75% for the food. Registered Nurse (RN) C was a few feet away from in the hall at the medication cart. RN C educated CNA H that the cups only held 240 ounces and since R465 left about an inch of fluid in the cup she should record 180 to 200 ounces. Due to only taking a few bites of food he informed CNA H that would be 25% for the food intake. During an interview with RD J on 9/18/24 at 8:38 AM, RD J was informed of the observations and interviews related to R465's fluid and food intake. RD J confirmed that the large cups on resident meal trays were 240 ounces and that it may be difficult to determine percentage of food eaten if the observer was not aware the portion size of the food served. No additional information about R465's fluid and food intake were provided upon exit.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interviews and record review, the facility failed to follow up on dialysis concerns for 1 Resident (R26) of 2 Residents reviewed for dialysis. Findings included: Review of R26's face sheet dated 9/17/24 revealed that she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: end stage renal disease, diabetes mellitus 2, congestive heart failure, bipolar disorder, epilepsy and major depressive disorder. R26 was her own responsible party. Review of R26's hemodialysis communication record dated 9/7/24 revealed a handwritten note in the section to be completed by dialysis center. c/o (complained of) intradialytic cramping. The section to be completed by facility upon return from dialysis was not completed. Review of R26's hemodialysis communication record dated 8/30/24 revealed a handwritten note, please put cream on full length of graft, Calcitriol 25 mg (medication to treat low calcium) and Novasource (renal nutritional supplement). Cramping end of treatment. This was in the section to be filled out by the dialysis center. The section to be completed by the facility upon return from dialysis was blank. Review of R26's hemodialysis communication record dated 8/14/24 revealed a handwritten note in the section to be completed by the dialysis center, symptomatic hypotension at end of run, 200 NS (normal saline) bolus. The section to be completed upon return from dialysis had partial vitals (blood pressure, pulse and respiration completed. No temperature. The part for site observation, port and residents' response to pain were not completed. There was no signature or return time. Review of R26's progress notes for these dates did not reveal any documentation of assessment after dialysis or acknowledgement of resident concerns listed by the dialysis staff. During an interview with R26's Unit Manager (UM) M, on 9/18/24 at 9:20 AM, the dialysis communication documents in R26's electronic medical record were discussed. UM M could not say who should address the dialysis communication or what the policy was at this time. During an interview the Director of Nursing (DON) on 9/18/24 at 10:42 AM the DON confirmed that she was not able to locate any documentation that the facility addressed R26's concerns listed on her dialysis communication forms. The DON said she had just started education that included staff are to complete the dialysis forms upon return. The DON said the dialysis was providing lidocaine cream (used to decrease pain sensation) to the facility and it was to be applied prior to going to dialysis. The DON did not have any validation that the facility was providing the lidocaine cream as directed by the dialysis center. The DON said she added this documentation to R26's electronic medical record today.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to ensure the pharmacist reported identified irregularities to the physician for 1 of 5 residents (R80) reviewed for monthly pharmacist Medication Regimen Reviews, resulting in the potential for the physician not being aware of drug irregularities. Findings include: A review of R80's Admission Record, dated 9/18/24, revealed R80 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 80's Admission Record revealed multiple diagnoses that included chronic kidney disease, diabetes, visual hallucinations, and bipolar disease. A review of R80's Pharmacy Medication Review Progress Notes, dated 10/1/23 to 9/18/24, revealed the following entries: - 2/29/24- Comment/Recommendation noted- see report. - 3/22/24- chart reviewed, one note to MD (physician). A review of R80's electronic medical record, dated 2/22/24 to 9/18/24, failed to reveal any reports and/or notes to the physician that detailed the recommendations and/or irregularities that the pharmacist had noted on their 2/29/24 and 3/22/24 medication reviews. During an interview on 9/18/24 at 12:30 PM, the Director of Nursing (DON) was informed that the surveyor could not find the pharmacist reports and/or notes describing the irregularities that were found by the pharmacist on 2/29/24 and 3/22/24 in R80's electronic medical record. The DON searched R80's electronic medical record with the surveyor and stated she also could not find R80's pharmacy recommendations for 2/29/24 and/or 3/22/24. She stated she was going to contact the pharmacist to get a copy of the recommendations for those dates. The surveyor requested copies of the pharmacy recommendations from the DON if the facility receives them. The DON verbalized understanding. During a second interview on 09/18/24 at 02:05 PM, the DON stated she still had not heard back from the pharmacist regarding their recommendations on 2/29/24 and 3/22/24 for R80. The surveyor again requested copies of the pharmacy recommendations from the DON if the facility receives them. The DON verbalized understanding. As of the completion of the survey and exit from the facility, the facility failed to provide any documentation related to the pharmacist's medication review recommendations/irregularities/findings for R80 on 2/29/24 and 3/22/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Addressing Medication Regimen Review Irregularities policy, reviewed/revised 12/28/23, revealed, It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident to identify irregularities and respond in a timely manner to prevent the occurrence of an adverse drug event . 2. The medication regimen of each resident must be reviewed by a licensed pharmacist at least once a month . 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon . b. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report which may be in paper or electronic form. c. The report will be sent to the attending physician, the facility's medical director and director of nursing . d. The attending physician must document in the resident medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record 5. The report should be submitted to the DON within 10 working days of the review .

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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. 31771 Based on interview and record review, the facility failed to adhere to the physicians ordered time frame for administration of a controlled substance (Oxycodone) when administered five hours early to one Resident (R63) of five residents reviewed for administration of controlled substances. Findings: Review of the Electronic Medical Record (EMR) revealed R63 initially admitted to the facility 5/16/23 with pertinent diagnoses that included chronic respiratory failure with hypoxia, asthma, and dementia. Review of the EMR Physicians Orders for R63 revealed an order entered 8/13/24 at 6:13 PM for Oxycontin Oral Tablet ER (extended release) 12-hour 30 milligram (mg) to be administered every 12 hours. Review of the facility document titled Controlled Substance Record for R63 for oxycontin ER 30mg reflected the medication was administered to the Resident at 12:00 AM on 9/15/24. The document reflected that the next dose was administered at 7:00 AM on 9/15/24, five hours before the Resident was due for the next dose. Review of the manufacturer's package insert for Oxycontin revealed this medication is a Schedule II controlled substance with an abuse liability similar to morphine. And OxyContin Tablets are NOT (bolded) intended for use as a prn (as needed) analgesic. The manufacturers package insert reflected Respiratory depression is the chief hazard from oxycodone. And Oxycodone should be used with extreme caution in patients with significant chronic obstructive pulmonary disease .having substantially decreased respiratory reserves .hypoxia, . or pre-existing respiratory depression as is included the EMR diagnoses of R63. The manufacturer's package insert went on to inform that In such patients, even usual therapeutic doses of oxycodone may decrease respiratory drive to the point of apnea (temporary cessation of respirations). On 9/18/24 at 11:58 AM the EMR Progress Notes for R63 were reviewed. The Progress Notes did not reveal any documentation since 9/13/24 at 11:36 AM. No documentation was found that a medication error had been identified, the physician had been contacted, or any incident, pain event, or respiratory monitoring of R63 had occurred on or about 7:00 AM on 9/15/24. On 9/18/24 at 1:07 PM the Director of Nursing (DON) reported that a medication with a scheduled time frame may be administered one hour before to one hour after the schedule time. The DON was asked about the administration of oxycontin to R63 on 9/15/24. The DON reported she would conduct a review of this administration episode. On 9/18/24 at 1:40 PM the DON reported I got nothing indicating that no information could be provided that this medication error had been identified or to explain how or why this had occurred. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy provided by the facility titled Medication Administration last reviewed/revised 1/17/23 was reviewed. The facility policy reflected, Policy: Medications are administered by licensed nurses .with professional standards of practice . And 11. Compare medication source (blister card with label) with (Medication Administration Record) to verify resident name, medication name .and time of administration. And b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. As of survey exit no additional information had been provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to maintain complete medical record for 3 of 23 sampled residents (R71, R102, and R415), resulting in the potential for providers not having an accurate and complete picture of the resident's stay at the facility. Findings include: Resident #71 A review of R71's Admission Record, dated 9/16/24, revealed R71 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 71's Admission Record revealed multiple diagnoses that included dementia, depression, anxiety, and schizophrenia. R71's Admission Record also revealed R71 was receiving hospice services. A review of R71's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 6/7/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 1 which revealed R71 was severely cognitively impaired. A review of R71's Hospice Consent Form, dated 4/2/24, revealed R71 began to receive hospice services on, or soon after, 4/2/24. A review of R71's electronic medical record, dated 6/17/24 to 9/17/24, failed to reveal any hospice aide visit notes. During an interview on 09/17/24 at 11:45 AM, the Director of Nursing (DON) stated she did not see the hospice aide visit notes in R71's electronic medical record. She stated she will check with the facility's medical records person to see if they may have the notes, but have not yet scanned them into R71's electronic medical record. She stated otherwise, she will have to contact the hospice company that provides services to R71 and get the notes from them. The surveyor requested a copy of R71's hospice aide visit notes, if the facility can locate them. The DON verbalized understanding. During a second interview on 09/17/24 at 01:00 PM, the DON stated she was still trying to get hospice notes. She stated their medical records person may have the notes scanned into a file in her computer and she (the medical records person) was still trying to locate them. The DON stated she will check with her and see if she found anything. She also stated that it is difficult to get hospice aide notes from the hospice company because they type everything into their system (the hospice company's). The DON stated the facility then must request those notes and they do not always get them. The DON stated the facility's medical records person cannot locate R71's hospice aide visit notes, then she (the DON) will contact the hospice company and request copies from them. The surveyor again requested a copy of R71's hospice aide visit notes, if the facility can locate them. The DON verbalized understanding. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a third interview on 9/17/24 at 4:00 PM, the DON stated the facility's medical records person could not locate any hospice aide visit notes for R71. However, she stated she was able to get the hospice aide visit notes from the hospice company, and they were scanned into R71's electronic medical record in two date range entries due to the volume of the documents. A review of R71's electronic medical record on 9/18/24 at 8:00 AM confirmed that R71's hospice notes were all scanned into R71's electronic medical record on 9/17/24. Resident #415 A review of R415's Admission Record, dated 9/18/24, revealed R415 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 415's Admission Record revealed multiple diagnoses that included Huntington's Disease, Alzheimer's Disease, and severe protein-calorie malnutrition. R415's Admission Record also revealed R415 was receiving hospice services. A review of R415's MDS, dated [DATE], revealed a BIMS score of 10 which revealed R415 was moderately cognitively impaired. A review of R415's Nurse Practitioner Progress Note, dated 9/6/24, revealed R415 was admitted to the facility on hospice services. A review of R415's electronic medical record, dated 9/5/24 to 9/17/24, failed to reveal any hospice aide visit notes. During an interview on 09/17/24 at 11:38 AM, the DON stated hospice staff have been to the facility to visit R415. The DON was informed that the surveyor could not locate any hospice notes (e.g., hospice aide, hospice nurse, hospice social worker, etc.) in R415's electronic medical record from 9/5/24 to 9/17/24. The surveyor requested a copy of all of R71's hospice visit notes, especially the hospice nurse and aide visit notes from 9/5/24 to 9/17/24, if the facility can locate them. The DON verbalized understanding. During a second interview on 09/17/24 at 01:00 PM, the DON stated she was still trying to get hospice notes. She stated their medical records person may have the notes scanned into a file in her computer and she (the medical records person) was still trying to locate them. The DON stated she will check with her and see if she found anything. She also stated that it is difficult to get hospice aide notes from the hospice company because they type everything into their system (the hospice company's). The DON stated the facility then must request those notes and they do not always get them. The DON stated the facility's medical records person cannot locate R415's hospice aide visit notes, then she (the DON) will contact the hospice company and request copies from them. The surveyor again requested a copy of R415's hospice aide visit notes, especially the nurse and aide notes, if the facility can locate them. The DON verbalized understanding. During a third interview on 9/17/24 at 3:30 PM, the DON stated the facility's medical records person could not locate any hospice visit notes for R415. However, she stated she was able to get the hospice visit notes from the hospice company, and they were scanned into R415's electronic medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235356	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge at the Shore	900 S Beacon Blvd Grand Haven, MI 49417

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R415's electronic medical record on 9/17/24 at 3:45 PM confirmed that R415's hospice notes were scanned into the medical record on 9/17/24. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www. nursingworld.org). 31197 R102 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R102 admitted to the facility on [DATE] with diagnosis of (but not limited to) heart failure, high blood pressure and iron deficiency anemia. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which represented R102 was cognitively intact. According to the progress notes dated 5/28/24, the Pharmacist documented a medication review and noted there was an irregularity that was reported to the physician. The electronic health record was reviewed to locate the irregularity report, but the Surveyor was unable to locate it. The Surveyor requested a copy of the irregularity report from the facility that the physician signed and responded to. During an interview and record review on 9/18/24 at 2:12 PM, the Director of Nursing (DON) provided a copy of Consult Pharmacist's Medication Regimen Review Recommendations Pending a Final Response for outcomes entered between 6/25/24 and 6/27/24 for review. A recommendation was made to monitor orthostatic blood pressures once monthly. The DON stated that these reports have multiple resident names on them and therefore not scanned into the electronic health record. The DON denied having a copy of the final report titled, Physician Recommendations that would include the physician signature who reviewed the recommendation. There was no evidence in the electronic record of the irregularity reported nor the physician response or acknowledgement. The facility provided a copy of the policy Addressing Medication Regimen Review Irregularities dated 10/30/2020 with a revised date of 12/28/23 for review. The policy reflected, d. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action as been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented for one resident (R5) of 23 residents reviewed for infection control practices. Findings include: R5 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R5 admitted to the facility on [DATE] with a readmitted [DATE] with diagnosis of (but not limited to) sepsis, diabetes and a right femur fracture. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R5 was cognitively intact. R5 required extensive staff assistance of 1-2 with all activities of daily living. During an observation on 9/18/24 at approximately 9:15 AM, R5 had a stop sign posted on her door that indicated providers and staff must wear gloves and gowns for the following high-contact resident care activity, Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central lines, urinary catheter, feeding tubes, tracheostomy, wound care: any skin opening requiring a dressing. After entering R5's room this Surveyor observed Certified Nurse Assistant (CNA) G and CNA H providing personal care to R5. Both CNA's were wearing gloves and no gown (as the sign on the door instructed). When asked if they needed gowns while providing AM personal cares, CNA G stated that they did not need to wear a gown and R5 was only on precaution for her IV. CNA G stated the nurse wears gloves and a gown when they administer medications through her IV line. When asked where the personal protective equipment (PPE) stand was kept for R5, CNA G searched the room and closet but was unable to find any in the room. During an observation, interview and record review on 9/18/24 at approximately 10:43 AM, this Surveyor and the Infection Control Preventionist (ICP) I observed the sign on R5's door. ICP I stated that R5 is on EBP's because of an IV line. ICP I stated that both CNA's should have had a gown on while providing personal cares to R5. ICP I searched R5's room and stated she was unable to locate the PPE stand and supplies for R5. ICP I stated she would re-educate the CNA's and place a PPE stand in R5's room.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 Based on interview and record review, the facility failed to ensure immunizations were offered and provided to one resident (R29) of 5 residents reviewed for immunizations. Findings include: R29 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R29 admitted to the facility on [DATE] with diagnosis of (but not limited to) diabetes, heart failure and chronic obstructive pulmonary disease. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R29 was cognitively intact. The facility provided a copy of the Pneumococcal Vaccine (Series) policy dated 3/1/22 last revised on 10/30/23 for review. The policy reflected adults ages 19-64 who had diagnosis of (but not limited to) diabetes, heart failure or chronic obstructive pulmonary disease should be offered the pneumococcal vaccine upon admission to the facility. The policy reflected, 10. For adults 19-[AGE] years old who have only received PPSV23: Give 1 dose of PCV15 or PCV20. During an interview and record review on 9/18/24 at approximately 10:45 AM, Infection Control Preventionist (ICP) I reviewed R29's immunization record with this Surveyor. The record reflected that R5 received a PCV23 (type of pneumonia vaccine) on 12/16/11. When asked if R29, according to the facility policy should have been offered a PCV20 (type of pneumonia vaccine) upon admission to the facility (on 11/25/23), ICP I stated, Yes. ICP I stated that she had recently did an immunization audit and discovered that several residents should have been offered the PCV20 but were missed. ICP I stated that she was in the process of educating and getting consents signed to give them.