STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235357	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Physical Rehab Ctr of Belding	414 E State St Belding, MI 48809

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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 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** 37872 Based on observation, interview, and record review, the facility failed to ensure a dignified dining experience for 8 of 11 residents, 7 of the residents including (R70 and R29) were being assisted by staff standing over them and one Resident (R82) watched residents eat for 20 minutes prior to being served his meal, resulting in an undignified dining experience for residents. Findings include: During lunch meal service on 4/1/24 at 12:04 PM, Certified Nurse's Aide (CNA) D was observed standing over three Residents while assisting them with their lunches. CNA D would assist one resident with a few bites, she would then stop/turn and assist another resident while the others watched. R70 A review of R70's Admission Record, dated 4/4/24, revealed R70 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 70's Admission Record revealed multiple diagnoses that included depression, anxiety, and alcohol dependence with alcohol-induced persisting dementia. A review of R70's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/12/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R70 had short-term and long-term memory problems with severely impaired cognitive decision-making skills. Further review of Functional Abilities Assessment (Section GG) 130 A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. Resident was coded as 1. Dependent on staff for assistance with eating. On 04/01/24 at approximately 12:07 PM, R70 was observed sitting close to the wall hands in his lap with multiple bowls and cups with straws in front of him. CNA D was standing over R70 few bites of his meal then moved over to assist another resident at his table. After CNA D moved R70 leaned over and proceeded chase the straw with his mouth around his cup. CNA D was heard telling him you can do it. (Get his straw/drink.) After approximately 3 minutes of unsuccessfully trying to get the straw in his mouth, R70's shoulders slumped, he sat back and stated he needed the bathroom. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/24 at 12:24 PM, CNA D was observed standing over and alternating between assisting R70 with his lunch and another resident. CNA D failed to practice proper hand hygiene techniques between residents. During an interview on 4/3/24 at 11:50 AM, Registered Dietitian (RD) L stated (Name of R70) was 1 to 1 dependent on staff for eating. During lunch observation on 4/1/24 at 12:04 PM, Certified Nurse's Aide (CNA) E stood at a round table assisting 4 dependent residents with their lunch. Observation of CNA E walking around the table counterclockwise, assisting the residents with a few bites (of their meal) and offering a drink, prior to assisting the next resident. CNA E continued to move from resident to resident assisting them with their lunch and wiping their mouths off. Hand hygiene practices were not observed in between residents. On 4/1/24 at approximately 12:18 PM, South CCC F entered the dining room and began assisting CNA E with Resident lunches. South CCC F was observed alternating assistance between the two residents. South CCC F failed to practice hand hygiene techniques while assisting residents. R29 A review of R29's Admission Record, dated 4/4/24, revealed R29 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 29's Admission Record revealed multiple diagnoses that included Cerebral Palsy, Dysphagia, COPD, and Epilepsy. During dining observation on 04/01/24 at 12:29 PM, Certified Nurse's Aide (CNA) E was observed standing over R29's broda chair while she assisted him with his lunch. Further observation of CNA E revealed she stood to assist R29 with a couple bites of his meal, offer a drink then moved on to assist another resident. During dining observation on 4/1/24 South CCC F was observed assisting R29 with his lunch. Further observation reflected South CCC F standing over R29 assisting him with his lunch. R29 was repeatedly instructed by South CCC F to put his chin down while she stood and assisted him. During a dining observation on 4/3/24 at 8:30 AM, Certified Nursing Aide (CNA) Q was observed sitting next to R29 and another resident on her phone. R29 was coughing and had a difficult time clearing his throat. After approximately 2-3 minutes CNA Q turns and provided the resident with another bite of breakfast. Further observation revealed the resident continued coughing; CNA Q was focused on her phone in between assisting R29 with his breakfast. R82 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R82 was admitted to the facility on [DATE] with diagnosis of (but not limited to) Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), dementia (memory and safety impairment), and history of falls. Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which represented R82 had severe cognitive impairment involving short- and long-term memory deficits. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/24 at approximately 10:00 AM, R82 was observed sitting next to the window at the dining room table. At 12:05PM, R82 was observed (still sitting at the table) licking his lips while he watched other residents eat (be assisted) with their lunches. Staff were overheard stating, he is in this dining room for lunch because he fell . Residents' meal was not brought out until Regional Nurse Consultant (RNC) P asked staff to go find it. R82 received his meal approximately 20 minutes after the last resident was served. During an interview on 4/1/24 at approximately 3:40 PM, DON revealed she was aware of the hand hygiene concerns during lunch. DON further revealed hand hygiene should take place in between assisting each resident and staff were being re-educated.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to obtain informed consent from the residents' responsible parties prior to administration of the medications for 2 of 5 residents reviewed (R70 and R87), resulting in the potential for the responsible parties not being informed that R70 and R87 were on psychotropic medications, not being informed of the indications for use of the psychotropic medications, the risks and benefits of the use of psychotropic medications, and the opportunity to decline the use of the psychotropic medications prior to administration. Findings include: R70 A review of R70's Admission Record, dated 4/4/24, revealed R70 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 70's Admission Record revealed multiple diagnoses that included depression, anxiety, and alcohol dependence with alcohol-induced persisting dementia. In addition, R70's Admission Record revealed he had a legal (court appointed) guardian. A review of R70's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/12/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R70 had short-term and long-term memory problems with severely impaired cognitive decision-making skills. A review of R70's Letters of Guardianship, dated 9/27/23, revealed Guardian (GRD) A was appointed R70's guardian. A review of R70's Medication Review Report, dated 4/4/24, revealed a physician's order on 2/15/24 for Zyprexa (olanzapine- an antipsychotic medication) 10 milligrams (mg) daily in the evening for restlessness and agitation and a change in the order on 2/27/24 to include the diagnoses of depression and dementia. A review of R70's Medication Review Report, dated 4/4/24, revealed a physician's order on 3/15/24 for Zyprexa 7.5 mg daily in the evening for restlessness and agitation. A review of R70's electronic Medication Administration Records, dated 2/1/24 to 4/4/24, revealed R70 received Zyprexa daily from 2/15/24 to 4/4/24 (except none on 3/15/24). A review of R70's Risk vs. Benefit/GDR (Gradual Dose Reduction) Form, dated 3/12/24, revealed a name was listed that was not R70's guardian's name as the person that was informed on 3/6/24 (20 days after R70 started receiving Zyprexa) of the indications (reasons) for use and risks vs. benefits of the use of Zyprexa (olanzapine). In addition, R70's electronic medical record failed to reveal anyone with the name that was listed on R70's Risk vs. Benefit/GDR Form as being anyone associated with R70 (specifically anyone who should be informed about R70's medical condition and/or medications). A further review of R70's electronic medical record, dated 2/1/24 to 4/4/24, failed to reveal that R70's guardian was even aware R70 was being administered Zyprexa. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/24 at 11:00 AM, the Nursing Home Administrator (NHA) was informed about the name listed on R70's Risk vs. Benefit/GDR Form as the one who was informed of the indications for use and the risks vs. benefits of the use of Zyprexa and was asked if he knew who the person was. He stated he did not know, but would find out. During an interview on 04/04/24 at 11:14 AM, the Director of Nursing (DON) stated she did not know who the person was that was listed on R70's Risk vs. Benefit/GDR Form as being informed about R70's Zyprexa indications for use and risk vs benefits of use. She stated she would find out and get back to the surveyor. On 04/04/24 at 02:00 PM, the surveyor received a copy of R70's Risk vs. Benefit/GDR Form from the facility, dated 4/4/24, that revealed GRD A was notified of the indications for use and the benefits vs risks for Zyprexa. During a second interview on 04/04/24 at 02:15 PM, the DON stated they do not know who the person was that was listed as being informed about R70's Zyprexa on R70's Risk vs. Benefit/GDR Form, dated 3/12/24. She stated, It was a typo even though the two names (the one listed on R70's form dated 3/12/24 and R70's guardian's name) were not close in spelling. The DON stated when the form was filled out, they meant to put GRD A's name on it, but instead put the other name on it. The DON stated they had e-mailed GRD A today (4/4/24) and GRD A had confirmed she was aware R70 was on Zyprexa, why R70 was on it, and the risks and benefits of its use. The surveyor requested a copy of that e-mail (the original and GRD A's response back). The DON stated she would provide that. A review of a Correspondence message, dated 2/25/24. revealed the facility left a message for GRD A informing her that the physician changed R70's medications from Seroquel (an antipsychotic medication) 50 mg to Zyprexa 10 mg due to R70 having urinary retention. The message requested that GRD A call the facility if they had any questions. However, the message did not indicate if GRD A received it and/or what date/time it was actually sent (the nurse did not click here to insert Name-Date/Time stamp in the Audit Trail section). In addition, the message did not give the reason why Zyprexa was being used (e.g., for depression, restlessness, agitation, dementia) except that it was replacing Seroquel and/or the risks and benefits of the use of Zyprexa. A further review of the Correspondence revealed the date of 2/25/24 was in an open format (Correspondence Date box was open with the cursor in front of the date where the writer would go to pick a date from the mini calendar next to it) which made it appear the date was not finalized. Therefore, there was no indication that the message was even completed and/or sent. During an interview on 04/04/24 at 02:40 PM, the DON stated the Correspondence message to GRD A was what the guardian sent back to the facility when they e-mailed her to ensure she was aware R70 was on Zyprexa and knew the reason for the use of Zyprexa and the risks vs benefits of Zyprexa. The DON verbally acknowledged that the Correspondence message did not have any identifying information on it (e.g., e-mail address, date/time sent to the facility as a response or received by the facility), any e-mail information as to when the original e-mail was sent to GRD A (e.g., in a chain e-mail with original message and responding messages), and/or any indication that GRD A responded back to the message versus the correspondence just being a one-way message from the facility to GRD A. The DON further stated that correspondence messages to guardians are not a part of the residents' medical records. R87 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R87's Admission Record, dated 4/8/24, revealed R87 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R87's Admission Record revealed multiple diagnoses that included depression, dementia with psychotic disturbance, visual hallucinations, and seizures. R87's Admission Record further revealed Durable Power of Attorney (DPOA) H was R87's responsible party for healthcare. A review of R87's MDS, dated [DATE], revealed a BIMS assessment which revealed R87 had short-term and long-term memory problems with severely impaired cognitive decision-making skills. A review of R87's Medication Review Report, dated 4/8/24, revealed a physician's order on 3/13/24 for Lorazepam (a psychotropic medication for anxiety) 0.5 mg two times a day for anxiety. A review of R87's electronic medical record, dated 3/1/24 to 4/8/24, failed to reveal any indication that DPOA H was informed of the risks and benefits of Lorazepam, the reason for its use, and the option to choose alternative treatment options. On 4/8/24 at 11:55 AM, a copy of R87's Risk vs. Benefit/GDR Form for Lorazepam or any other documentation that would reveal DPOA H was informed of the risks and benefits of Lorazepam, the reason for its use, and the option to choose alternative treatment options prior to R87 being administered Lorazepam was requested from the DON. On 4/8/24 at 12:24 PM, a copy of R87's Risk vs Benefit/GDR Form, dated 4/8/24, was provided to the surveyor. It revealed DPOA H had been made aware of the indications for use and risk vs benefits of use of Ativan (Lorazepam). However, the form indicated DPOA H had been informed 26 days after R87 started receiving the Lorazepam.

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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 Based on observation, interview, and record review the facility failed to provide a clean, comfortable and home like environment to ensure that Resident #44's room was clean and uncluttered to allow safe access to the bed and oxygen concentrator, resulting in the potential for falls and the inability to provide appropriate oxygen therapy. Findings Include: A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #44 was admitted to the facility on [DATE] with diagnoses: Bipolar disorder, heart disease, Chronic obstructive pulmonary disease, dependence on oxygen, chronic respiratory failure. The MDS assessment dated [DATE] indicated the resident was independent with most care and had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 15/15. On 4/01/2024 at 12:39 PM, during a tour of the facility, Resident #44 was observed sitting on her bed. She had a variety of personal possessions piled on the floor from the wall towards the end of the bed. There were additional items on the floor on the other side of the bed by the window including a large Rubbermaid tote. The bed was inaccessible on that side due to the items on the floor. The resident said she was going to organize her belongings into the tote; there were too many items to fit into one tote. The resident said she was not offered extra storage or shelves. There was also a large garbage bag with empty pop cans sitting on the counter into the sink. During the observation on 4/1/2024 at 12:39 PM, Resident #44 was observed wearing a nasal cannula for oxygen, but neither an oxygen concentrator nor oxygen tanks were observed. When asked where the oxygen was, the resident pointed towards the wall. Behind her belongings up against the wall was an oxygen concentrator. The oxygen had to be accessed from the other resident's side of the room, because there were too many items stored on the floor in front of it. On 4/03/24 at 9:15 AM, Nurse Manager I was asked if she would accompany the surveyor into Resident #44's room. The resident was observed sitting on her bed. There was almost no floor space for the resident to enter and exit the bed. The clutter was several feet high. The large bag of empty pop cans was on the floor. Reviewed with the Nurse Manager I that the clutter was a safety concern; also reviewed the oxygen concentrator could not be accessed from the resident's side of the room due to clutter. The resident commented she needed to clean up her belongings as she could barely get to her bed, and she didn't want to fall. A review of the Care Plans for Resident #44 revealed the following: I have a potential for hoarding/clutter . date initiated 1/3/2023 with Intervention: Staff will offer to clean/tidy my room every Wednesday as I allow, date initiated and revised 1/3/2023. There was not documentation that this was consistently attempted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I am at an increased risk for falls related to COPD with oxygen use, seizure disorder, acute and chronic respiratory failure with hypoxia, (heart disease), bipolar disorder, peripheral neuropathy, history of (urinary tract infection), and possible medication side effects. My room tends to get cluttered with my belongings presenting a trip hazard, date initiated 11/17/2022 and revised 1/13/2023, with Interventions: I have a parking spot for my walker marked on floor next to bed, date initiated 10/24/2023; Reduce my risk for falls by cleaning up spills and clutter from my floor . date initiated 11/17/2022. The resident had too much clutter on the floor to visualize a marked spot on the floor for a walker. The clutter remained.

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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** 31771 Based on observation, interview, and record review the facility failed to revise the Care Plan to meet identified care concerns for two residents (Residents #82 and R#101) and failed to implement revisions to the plan of care for one Resident (R70). Findings Include: 31197 The facility provided a copy of the Fall Reduction Policy dated 2/14/02, last revised date 4/2023 for review. The policy reflected, 2. The nurse will initiate interventions on the resident's baseline care plan, in accordance with the resident's identified risks .a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed . R82 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R82 was admitted to the facility on [DATE] with diagnosis of (but not limited to) Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), dementia (memory and safety impairment), and history of falls. Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which represented R82 had severe cognitive impairment involving short and long term memory deficits. R82 had a resident representative for all medical decision making. During an observation and interview on 4/4/24 at 3:26 PM, R82 was observed seated in the dining room at the table with his back to the TV. R82 was unable to answer any specific questions related to his falls. The Activities of Daily Living (ADL) care plan dated 1/11/24 was reviewed on 4/4/24. The care plan reflected, MOBILITY: I ambulate with 1 assist using a 4 wheeled seated walker. Provide cues for redirection as needed. Date Initiated: 1/11/24, Revision on 3/28/24 .TOILETING: I require 1 assist with peri care. Revision on 1/26/24 .TRANSFERRING- 1 assist with walker as I will allow. Revision on 3/29/24 . According to the physician's noted dated 3/27/24 at 11:15 AM, Pt (patient) is ambulatory but has an unsteady gait. He has Parkinson's festinating gait (individuals with Parkinson's disease, marked by short, shuffling steps that begin slowly but increase in rapidity until the walk becomes a half run. The body leans stiffly forward to maintain balance, and there is an associated risk of falling) and falls every time he turns or turns to sit down . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 4/8/24 at 10:39 AM, the Director of Nursing (DON) stated that R82 had a physical therapy (PT) evaluation on 1/12/24 that stated R82 was determined to be unsafe with turning with his walker and recommended 1 assist. The PT evaluation further stated that due to poor safety awareness R82 required the assistance of 1 at all times with mobility. The DON stated that the evaluation on 2/22/24 reflected that R82 requires 1 assist with transfers at all times as he allows because he cannot sense chair placement and misses when he attempts to sit. The DON stated the care plan was updated on 3/29/24 (2 months after the evaluation and recommendations were initially made). According to the falls (13 of them) reviewed from 2/20/24 - 4/8/24 reflected R82 did not have the assistance required to maintain his safety. The care plan was not updated or revised to reflect the recommendations of the 1/12/24 PT evaluation until 3/28/24 and R82 continued to self-ambulate and sustain minor injuries. R101 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R101 admitted to the facility on [DATE] with diagnosis of (but not limited to) acute gastric ulcer, kidney disease, and blood clot to right leg. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which represented R101 was cognitively intact. During an observation and interview on 4/2/24 at approximately 12:40 PM, R101 was seated in her wheelchair in the dining room. R101 was observed feeding herself and stated the food here is okay. According to the Nutritional assessment dated [DATE] reflected that R101's current body weight was 164.4 lbs. and reported that it was stable for her. The assessment reflected, 16a. My nutrition goals while here are: maintain nutritional status AEB (as evidenced by) weight maintenance . There is no mention of issues with edema or desire for planned weight loss. The weight log was reviewed from admission 2/24/24 - 4/2/24: 2/24/24 164.4 lbs. 2/26/24 164.4 lbs. 2/27/24 164.4 lbs. 3/9/24 155.0 lbs. (9.4 lbs. lost in 10 days, 5.72%) The physician note dated 3/1/24 reflected that R101 complained about pain in her lower extremities due to edema and the plan to start a diuretic for 3 days. The MDS note on 3/1/24 reflects that Lasix 20 mg will be given for 3 days to decrease the edema and pain. Record review of the Care Conference note dated 3/14/24 at 9:47 AM did not reflect the recent weight loss of 9.4 lbs or changes in care planning regarding nutrition, hydration, edema, or weight monitoring. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Weight Change Note dated 3/27/24 (18 days after the weight loss was noted) reflected and identified weight loss of 9 lb x 1 month and the Plan: Hospital weight was 150 lb and admit weight was 164 lb. Suspect weight fluctuations or inaccuracies, will continue to monitor weight trends weekly . According to the Nutrition and Hydration care plan dated 2/28/24 last revised on 2/28/24 reflected no issues with edema in the focus area of the care plan. The goal reflected, My nutrition goal, is to maintain nutritional status AEB (as evidenced by) weight maintenance. Dated 2/28/24. During an interview and record review on 4/3/24 at approximately 10:00 AM, Registered Dietitian (RD) L stated that she over sees the weight changes in the facility. When asked if it was R101's planned goal to lose weight, RD L stated according to her care plan no. When asked who monitors the weight changes at the facility, RD L stated, I do. When asked who requests for a resident to be reweighed to ensure accuracy of weights, RD L states that she does when indicated. When asked if her 9.4 lbs. weight loss might be an indication, RD L stated there is no specific guidance about that. RD L stated that she found that R101 weighed 150 lbs. in the hospital records, used that as her usual weight and cleared the weight warning she received to notify her. The RD L was asked to review that hospital record with the Surveyor, and it could not be determined if the weight recorded was an actual or a stated weight. RD L also included that R101 was provided a diuretic on 3/2/24, 3/3/24, and 3/4/24 for edema. When asked if the staff reweighed R101 after that to check the effectiveness of the diuretic, RD L stated no. R101 sustained a significant weight loss of 9.4 lbs. lost in 10 days, 5.72%. There was no assessing and monitoring to review after the use of a diuretic (from 3/4/24 - 4/2/24) to ensure accurate weight monitoring. The care plan was not updated or revised to reflect the issue of edema and its management. 37872 R70 A review of R70's Admission Record, dated 4/4/24, revealed R70 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 70's Admission Record revealed multiple diagnoses that included depression, anxiety, and alcohol dependence with alcohol-induced persisting dementia. A review of R70's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/12/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R70 had short-term and long-term memory problems with severely impaired cognitive decision-making skills. Further review of Functional Abilities Assessment (Section GG) 130 A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. Resident was coded as 1. Dependent on staff for assistance with eating. Review of Resident's Kardex (a tool used by staff that informs them on how to provide care/assistance to residents) dated 4/2/24 reflected under Eating/Nutrition R70 needs Adaptive equipment, I require: scoop plate and straws. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R70's Care Plan with Revisions (Last Care Plan Updated 4/01/24) reflected the following Interventions/Tasks for Eating- 1 to 1 assist for feeding, ensure I am upright and alert for intake, ensure bite is swallowed before offering another. Date initiated:09/08/2023, Revision on: 01/24/2024. Further review of R70's Care Plan reflected EATING-set up assistance Date initiated: 09/08/2023 Revision on 12/19/2023 Intervention/task was discontinued. On 04/01/24 at approximately 12:07 PM, R70 was observed in the South Lower-Level Dining Room sitting close to the wall, hands in his lap, with multiple bowls regular spoons and cups with straws in front of him. CNA D was standing over and gave R70 a few bites of his meal then moved over to assist another resident at his table. After CNA D moved R70 was observed trying to get a drink in front of him. R70 leaned over and proceeded chase the straw around the cup with his mouth. CNA D was heard telling him you can do it. (Get the straw/drink.) After approximately 3 minutes of unsuccessfully trying to get the straw in his mouth, R70's shoulders slumped, he sat back and told CNA D he needed the bathroom. During dining observation on 4/1/24 between 11:45 AM - 12:50 PM, CNA D and CNA E revealed that they do not usually work on the unit. CNA's further revealed they did not really know the residents and had only assisted them a couple of times. During a meal observation on 4/3/24 at 8:29 AM, R70's breakfast tray is observed on a cart with 3 bowls, and 3 cups with lids that have sip spouts. During an interview on 4/3/24 at 11:50 AM, Registered Dietitian (RD) L revealed R70, Needs a scoop plate and straws in order to eat and he is a 1 to 1 dependent for eating.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to ensure medications were administered per standards of practice for 3 residents (#'s 60, 93 and 405) reviewed for medication administration, resulting in the lack of nursing presence during medication administration for two residents (#'s 60 and 93) without assessment for self-administration of medication and administering medications outside of the physician prescribed orders for Resident #405, which could lead to adverse effects. Findings Include: Resident #60 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #60 was admitted to the facility on [DATE] with diagnoses: History of a stroke, history of brain and ovarian cancer, Alzheimer's Dementia, heart disease, history of falls with vertebral fracture, anxiety, depression, diabetes and lymphedema. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss and needed assistance with all care. On 4/02/24 at 9:00 AM, observed Nurse B bringing medications into Resident #60's room. She set them on the counter in 2 medication cups and the residents husband began to organize them on a paper towel with a spoon. He said he normally gave her the medications as he speaks to the resident in Spanish and he said she did better when he gave them to her. He said it normally took a while to give them because he provided them one at a time. He asked the nurse why she was staying in the room, because he said the nurses usually did not stay and watch. He said the nurse was watching because the surveyor was in the room. The nurse confirmed she usually did not stay in the room during the medication administration. On 4/03/24 at 10:07 AM, Interviewed Nurse Manager I related to observation of the resident's husband passing medication without the nurse in the room. An assessment could not be located that the resident's husband was able to assist the resident in medication administration. The Nurse Manager was asked about it and she said the nurse was supposed to stay in the room while the resident received her medications. The Nurse Manager said she stayed in the room while the resident received medications when she administered them herself. The Nurse Manager said she could review self -administration of medications with the resident's husband, so that he could assist the resident. Currently there was no process in place for the resident's husband to give the medications. Resident #93 A record review of the Face sheet and MDS assessment indicated Resident #93 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Quadriplegia, chronic pain, chronic obstructive pyelonephritis, acute respiratory failure, pressure induced deep tissue damage of right ankle, chronic ulcer left foot, history of traumatic brain injury, polyneuropathy and anxiety. 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 needed assistance with all care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/24 at 9:13 AM, upon entering the resident's room with Nurse Manager I. Resident #93 was observed with an oxygen mask on and was receiving a breathing treatment. There was no nurse in the room, the resident confirmed the nurse had placed the mask, started the treatment and left the room. Nurse Manager I said the nurse should have remained in the room with the resident during the breathing treatment and she would stay in the room until the treatment was finished. Resident #405 A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #405 revealed an admitted to the facility on [DATE] and readmission on 3/9/2024 with diagnoses: Meningitis, brain abscess, brain and lung cancer, diabetes, chronic kidney disease, history of pulmonary embolism. The MDS assessment dated [DATE] indicated the resident had moderate cognitive impairment with a Brief Interview for Mental Status/BIMS score of 11/15. On 4/02/24 at 8:22 AM, during a tour of the facility, Resident #405 was observed to have an IV running via an electronic pump. He said it was an antibiotic for a brain infection. The resident said he had many health issues and had a history of brain surgeries. The resident said he received the IV antibiotic in the morning and evening. The IV bag read Ceftriaxone an antibiotic. On 4/03/24 at 8:15 AM, Nurse G said she had already provided the IV antibiotic Ceftriaxone for Resident #405. The Nurse was asked when it was provided and she looked in the electronic medication administration record/MAR; it showed the time the antibiotic was given was 0712/ 7:12 AM. The MAR also identified the antibiotic was given on 4/2/2024 at 8:24 PM, and 4/2/24 at 7:17 AM. She identified on her MAR that it showed AM PM and she said she could give it between 0700-1000. The order was reviewed and it was ordered every 12 hours. The nurse said she had between 0700 -1000. A review of the physician orders revealed the following: Ceftriaxone sodium Intravenous solution reconstituted 2 GM/Ceftriaxone Sodium: Infuse 2GM (50ml) Intravenously every 12 hours *Infuse over 30 minutes for 4 weeks* Entire contents of bag must be infused to ensure complete dose is given, start date 4/2/2024. On 4/03/24 at 8:33 AM, during an interview with the Director of Nursing/DON about Resident #405's antibiotic, she said the antibiotics are given per pharmacy policy and how the physician wants them specifically given. Reviewed the order for Resident #405 for every 12 hours; the DON said it should be given every 12 hours, not between 0700 and 1000. The DON said the antibiotic should not be given as AM and PM; she said the Unit Managers should be monitoring that and she would speak to them. A review of the facility document for medication administration identified the following: Standard Med Pass Times: Q12 H (every 12 hours) 0900, 2100 (9:00 AM and 9:00 PM).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This Citation pertains to Intake MI00142041 Based on observation, interview, and record review the facility failed to ensure meaningful Activities were provided to 1 facility residents directly (Resident #53 (R53)) and all facility residents in the S-1 and S-2 memory care units resulting in unengaged cognitively impaired resident not engaged in activities that a reasonable person would partake in to avoid boredom and to seek a sense of self-worth. Findings: R53 was originally admitted to the facility 3/7/19 and has current diagnoses that include Dementia, Anxiety, and Major Depressive Order. Review of the Minimum Data Set (MDS) dated [DATE] reflected R53 is severely cognitively impaired, is rarely or never understands or is understood, and has highly impaired vision. Review of the MDS section F for Preferences for Customary Routine and Activities reflected R53 enjoys Doing things with groups of people, and Participating in favorite activities. Review of the Care Plan for R53 revealed a Focus of I am here for long term care and will be invited to participate in the activity program initiated 3/12/19. The Goal of this Care Plan area reflected I will attend groups that I have a preference in and I will participate in individual leisure activities as desired. The Interventions to be implemented to reach this goal for R53 included leafing through books and magazines and doing things with groups of people and doing my favorite activities Further interventions included games that require strategy/ concentration, trivia, socials, coloring outdoor visits, reading groups. These interventions appear to exceed the capabilities of R53 as indicated by the MDS of 1/30/24. On 4/8/24 at 3:40 PM a review was conducted of the EMR of R53 for documentation for group activities and one on one (1:1) activities that R53 had been engaged in or offered for the previous thirty days. The review for both the Group and 1:1 activities revealed no documentation that R 53 had been offered or had participated in either. The facility has two adjoining memory care units, S-1 and S-2, for cognitively impaired residents. At the time of this survey 52 residents were residing in these two units with a total facility census of 104 residents. The S-1 unit and the S-2 unit each has its own separate dining area but residents can freely move between units. R53 resides in the facility S-1 memory care unit. On 4/02/24 8:45 AM an observation was made at the S-1 Dining Room of R53 is sitting at a table by herself rubbing the top of the table and talking to herself. No staff in room. At 9:24 AM R53 remains at the table rubbing the tabletop and occasionally verbalizing nonsensical speech. At 9:38 AM eleven residents are in the S-1 Dining Room, but no staff were present. A television was on, but no residents were observed watching the television. At 9:52 AM eight residents remain sitting scattered about the large dining area unengaged in any activity. At 10:17 AM Activities staff was observed playing a card game with three residents and the other five resident were unengaged in any activity or diversion. R53 remains as previously noted. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/02/24 3:58 PM eleven residents were observed in the S-1 dining room. No activities in progress. The residents were observed scattered about the room sitting at tables just looking around or staring. Three residents appeared to be sleeping. The television was on, but no one was near or watching. On 4/08/24 at 1:36 PM seven residents were observed in the S-1 dining room. Four residents appear to be sleeping in chairs, three residents sitting at separate tables each had a doll sitting in front of them on the table. The television was on, but no residents were observed watching the this. Outside the dining room in a common area were five residents sitting in chairs with one resident laying on a love seat. No activities or any resident engagement was observed. On 4/02/24 at 10:36 AM an interview was conducted with Activities Director (AD) U reported just after the beginning of 2024 staffing adjustments left her with only one assistant for the entire facility Activities program. AD U reported conducting an Activities program is beyond challenging for her and the one assistant. AD U reported she was only able to keep the assistant because of the two memory care units. AD U reported that prior to the staff cuts she always had two staff in the memory care units and two staff for the rest of the facility residents. AD U indicated at that time the Activities staff were effective in keeping residents engaged in meaningful activities. On 4/2/24 at 7:19 AM Registered Nurse (RN) V, who often works in the memory care units acknowledged staffing was cut some time after the first of the year. RN V reported that Activities staff were instrumental in keeping residents on both the S-1 and S-2 units engaged and busy. RN V indicated that the residents just don't get the attention they used to get, and the Certified Nurse Aide (CNA) staff just don't have the time to engage residents in Activities as they are addressing care needs. Review of the facility Activities Calendars for January, February, and March 2024 reflected two activities a day are scheduled at 10:00 AM and 2:00 PM five days a week. The calendars did not reflect any recreational Activities on weekends or in the evening. Review of the Activities Calendars revealed several activities are performed only on the general area of the facility and not in the locked memory care units. On 4/08/24 at 1:53 PM a second interview was conducted with AD U. AD U acknowledged that some activities were performed only outside the memory care units. AD U reported for those activities she does try to integrate memory care residents into those activities. At times she can take 10 or 12 of the 52 memory care residents up to engage in those activities. AD U did indicate that memory care residents sometimes do not have the abilities to engage in some of those activities. At no time during this survey was R53 observed to be engaged in any activity as the documentation of the Resident's EMR indicated. 37872

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F 0684 Level of Harm - 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** 31771 This Citation has two Deficient Practice Statements (DPS) DPS #1 This Citation Refers to Intake Number MI00142983 Based on observation, interview, and record review the facility failed to identify, assess, properly monitor, and treat mental and/or physical changes in condition and failed to accurately and timely document changes for two Residents (Resident #85 (R85) and R76) resulting in admission to an Intensive Care Unit in critical condition for R85 and delay in treatment for R76. Findings: R85 Review of the electronic medical record (EMR) reflected R85 originally admitted to the facility 8/26/22 and had diagnoses that included: Pseudobulbar Affect (characterized by uncontrolled outburst of laughter or crying), Manic Depression (Bipolar Disease), Dementia and Anxiety. Review of the Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 11/28/23 reflected a score of 2 out of 15 which indicated the Resident was severely cognitively impaired. Section GG of this MDS revealed R85 was functionally able to ambulate independently, could eat on her own with set- up assistance, and could toilet independently. Review of the EMR Progress Note dated 2/23/24 at 5:30 PM that R85 was to be transported to the hospital for Altered mental status and Functional decline. The entry reflected, At the time of evaluation resident/patient vital signs . were blood pressure (BP) of 132/92, although this result was documented as obtained on 2/18/24. Other vital signs documented as obtained at the time of the evaluation include a pulse of 60 beats per minute (BPM) and a temperature of 98.9 degrees Fahrenheit (F). Review of the Emergency Medical Services (EMS) document titled Prehospital Care Report Summary (also known as a Run Report) reflected EMS arrived on scene at 6:04 PM, 34 minutes after the above vital signs were documented. The vital signs obtained by EMS included a pulse of 135 BPM, respiratory rate of 34 breaths per minute, a BP of 133/106 and a temperature of 103.0 F. Review of hospital emergency room records reflected initial vital signs included a core body temperature of 102.74 F, pulse of 141, and a respiratory rate. of 30. Initial laboratory blood test results included a sodium level of 168 (normal of 134 to 146) which was redrawn to confirm the critically high abnormal value. A white blood count (wbc) lab result of 17.12 (normal range of 4 to 10.8. A high result is indicative of a systemic infection). A urinalysis reflected results that included that the urine specimen of R85 was red and tested positive for blood, white blood cells (infection), and protein. Blood cultures were also obtained and later reflected positive for staphylococcus and gram-positive cocci. Hospital physician documentation included: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility reported (to the hospital) that R85 had increases in her Zyprexa (an antipsychotic medication) and clonazepam (a benzodiazepine often prescribed for the treatment of panic disorders)) two weeks ago which was thought to be the cause of the (R85) having increased weakness and decrease in mental status over last two weeks. And On arrival, (R85) was febrile (fever), tachycardic (high heart rate), had leukocytosis (high white blood cell count), lactic acidosis (potentially life-threatening build up of lactic acid in the blood), an (Acute Kidney Injury) AKI, severe hypernatremia (high sodium blood level), and was minimally responsive. Her (urine) was positive for leukocytes (white blood cells), nitrites, and blood. On exam, she opens her eyes but does not otherwise respond to staff. And .she did have a drop in her blood pressure and required fluid resuscitation .recheck of sodium (lab level) did confirm hypernatremia (high sodium level) . And Critical Care time (treatment) was required due to the life-threatening nature of this patient's condition . Also On arrival patient appears septic., and She did have strong urine odor . The hospital documentation reflected R85 was admitted to the Intensive Care Unit (ICU) in critical condition with diagnoses that included Severe sepsis, Acute metabolic encephalopathy severe and life-threatening with Hypernatremia secondary to free water loss (dehydration) likely contributing to above, Acute cystitis with hematuria, Acute Kidney injury. Subsequent Hospital Course physician documentation included I am concerned for polypharmacy (taking many prescribed drugs), SS (Serotonin Syndrome (SS) symptoms include high heart rate, high blood pressure, confusion, and high fever as a reaction to medication) or Neuroleptic Malignant Syndrome (NMS) . (NMS is a life-threatening reaction to antipsychotic medications characterized by high fever, altered mental status, high heart rate, rapid breathing and high or low blood pressure). Hold all possible drugs that could contribute (listed are medications R85 had ordered at the facility) And Social work consult to determine if (R85) was left in an minimally responsive state for a week given how dehydrated she was Another physician documented, Social work consult to determine if (R85) was left in a minimally responsive state for a week. If so, concern for neglect . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility EMR was reviewed for the chronology leading to the admission of R85 to the intensive care unit. Review of the Doctor's Orders for R85 reflected Lorazepam (a controlled substance (benzodiazepine)) was prescribed initially on 8/22/23 which was renewed or had the order changed multiple times until 2/7/24. However, the EMR did not reveal that a Risk versus Benefit had been completed for this Resident to take this medication. Other medications R85 was receiving on 2/7/24 included Zyprexa (prescribed for bipolar disorder), pristique and trazodone (antidepressants), L-methyl folate (for depression or adjunct therapy with antidepressants), and Nuedexa (a central nervous system agent used to treat pseudobulbar affect). Review of the EMR reflected on 2/7/24 Lorazepam was discontinued, and clonazepam was ordered. The EMR did not reflect a Risk versus Benefit was completed for use of the clonazepam for R85. Also, on this date the order for Zyprexa had changed along with the addition of the Clonazepam. During an interview conducted 4/8/24 at 11:01 Social Worker (SW) S she initiates the Risk and Benefit form in the EMR anytime a resident has a Doctor's Order for a hypnotic, antidepressant, antipsychotic, anxiolytic, or mood stabilizer. SW S reported that she missed the Ativan order and did not catch the Doctor's Order for the clonazepam for R85. Therefore, Risk versus Benefit forms were not completed when R85 started on these two medications. SW S reported that there are a lot of pieces when a medication requiring a risk versus benefit is ordered to include Care Plan changes and monitoring. SW S reported that a task is added for monitoring but not until a week after the medication was initiated to give the medication a fair chance to take effect. Review of the Practitioner Progress Note completed by Physician Assistant (PA) T dated 2/7/24 at 8:05 AM included documentation of the medication changes. However, this note of 2/7/24 also included documentation of vital signs that were taken after this date to include a BP taken on 2/18/24, a pulse and oxygen saturation taken on 2/23/24 and a pain scale result dated 2/16/24. Further review of this 2/7/24 note by PA T revealed that this entry and two entries dated 2/20/24 by PA T were created and entered as Late entries into the medical record on 2/26/24 which was three days after R85 was admitted to the hospital ICU. Review of the EMR Progress Note dated 2/15/24 at 8:46 PM revealed, (R85) noted to be very tired. Refused supper. Refused popcorn and pop for snack which is very unusual, she has a flat affect and poor eye contact. I could not even get her to look at me . Very hard to get her medications in her. She needed help to get them to her mouth and reminders to swallow them. No documentation of vitals signs or further assessment or monitoring were located regarding this entry. The Late Entry Practitioner Progress Note by PA T dated for 2/20/24 at 8:36 AM but created 2/26/24 reflected Staff are concerned as (R85) is no longer anxious, restless, or crying but has started to have a blank stare to her the past week or so and she is not verbally communicating very well anymore. The documentation reflected PA T did observe that R85 does have a blank stare to her and has been eating less with meals. And Flat affect with blank stare look to her, generalized weakness, confused and disoriented, and Unsteady gait. Medication orders were changed per this entry. The vital signs documented in this note were from 2/18/24 and 2/23/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The second Practitioner Progress Note by PA T entered as a Late Entry for 2/20/24 at 4:28 PM but created on 2/26/24 at 8:51 AM was reviewed. The entry reflected (R85) was revaluated (sic) later on today to see if there has been any improvement with recent med change, (R85) seems a bit worse. Medication orders again changed in the PM note in addition to the changes documented in the late entry from the AM of this same day Review of the Medication Administration Record (MAR) for February 2024 for R85 reflected four separate sections for monitoring for adverse side effects of medications. One section each was established for an anti-depressant, anti-psychotic, anxiolytic, and one for General Anticholinergic effect. Each section was documented in three times a day. A positive finding required this to be noted in the MAR with a Nursing Progress Note entry. Side effects to be observed for and documented included, altered mental status, excessive sedation, dry mouth, confusion, drowsiness, lethargy, irregular heartbeat/pulse. Review of these four sections of monitoring reflected staff initials of no abnormal findings despite staff reports of concerns alleged by PA T. Review of the EMR vital signs history from 2/7/24 until 2/23/24, when R85 was transported to the hospital, vital signs were only obtained twice (2/11/24 and 2/18/24) despite Progress Note documentation of difficulty taking medication, decreased communication, lethargy, and altered mental status (blank stare for the past week or so). No further Progress Notes regarding the mental or physical status of R85 are documented until the Resident was transported by EMS to the hospital where she was admitted in critical condition. On 4/4/24 at 3:27 PM an interview was conducted in an office with the Director of Nursing (DON). The DON reported she expects timely entry of Progress Notes. The DON reported that increased monitoring of R85 should have been ordered after the 2/7/24 evaluation by PA T. After reviewing the late entries of 2/20/24 by PA T the DON reported that the PA thought it was alarming enough to put in a note that the abnormal observations of R85 should have been acted upon. The DON stated, I have no idea why (PA T) made two notes (on 2/20/24) It just makes no sense to me. The DON reported that PA T is no longer at the facility and that the timeliness of pertinent documentation was part of the reason. The DON reported that nurses should have acted upon the findings that were documented in the EMR on 2/15/24 (lethargy, refusing food, helping R85 get medication into her mouth with reminders to swallow). The DON reported an expectation that vital signs would have been taken and the medical provider contacted. The DON reported she was not in-house during the time period prior to the hospitalization of R85 but that she would have been aware of the Resident's status and would have responded appropriately. The DON reported she had no further documentation or information to provide. No further documentation was provided prior to survey exit. 31197 R76 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R76 admitted to the facility on [DATE] with diagnosis of (but not limited to) Stroke with weakness, morbid obesity, and history of blood clots to both lower extremities. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R76 was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/1/24 at approximately 2:00 PM, R76 was resting on his bed working on his computer. R76 stated that he had a fever yesterday (3/31/24) and he has a history of cellulitis in his lower legs. According to the progress notes on 3/31/24 at 1:39 PM, the note reflected, patient flush and warm to the touch. Axillary temp 101.4. denies s/s (signs and symptoms) feeling ill. No other s/s noted at this time. Administered Tylenol at 1:15 PM. Passed to next shift to monitor. At 3:01 PM the physician was notified of the fever and recommended, Alternated [NAME] (Tylenol) with Ibuprofen. Dip urine. According to the Temperature Summary reviewed from 3/31/24 - 4/2/24 the following temperatures were recorded for R76: 3/31/24 at 2:30 PM 102.9 (degrees Fahrenheit) 3/31/24 at 3:11 PM 102.6 3/31/24 at 4:15 PM 101.6 3/31/24 at 5:20 PM 101.2 3/31/24 at 5:47 PM 101.2 3/31/24 at 6:14 PM 99.9 3/31/24 at 9:58 PM 98.9 There were no further temperatures recorded from 3/31/24 -4/2/24 to review. A skin assessment documented on 3/31/24 at 10:45 PM was reviewed and reflected red open areas to the back of both thighs, and both buttocks. There was a rash to the right abdominal fold and the right axilla. Both legs were red with indentions. The assessment noted treatments in place for all areas. During a follow-up interview and observation on 4/3/24 at approximately 8:36 AM, R76 was resting in bed. When asked if his fever had come back, R76 stated that he didn't know. R76 stated that his lower leg was reddened and showed this surveyor the right lower leg with redness noted from the just below the knee to the ankle. When asked if the doctor had started him on an antibiotic for it, R76 stated, No, I don't think so. Record review of the medication administration record (MAR) for March 2024 and April 2024 reflected no order to alternate Tylenol and Ibuprofen for a fever. The Ibuprofen 200 mg, give 400 mg by month every 4 hours as needed for fever was started on 4/2/24 (not on 3/31/24 as the doctor had recommended). There were no antibiotic orders listed on the MAR at the time of this record review on 4/3/24 at approximately 8:45 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview and record review on 4/3/24 at approximately 9:00 AM, the Clinical Care Coordinator (CCC) I reviewed R76's progress notes, temperature logs, physician notification and MAR with this Surveyor. There were no temperatures logged from 4/1/24 - through the time of this interview. When asked if the staff monitored R76's temperature after 3/31/24, CCC I stated that there were none recorded. When asked if the order to alternate Tylenol and Ibuprofen was initiated on 3/31/24, the CCC I stated that it did not get onto the MAR until 4/2/24 (2 days after receiving the order from the physician). When asked if the urine was collected for testing, CCC I stated that R76 refused because it is too painful for him. When asked if the physician was made aware, CCC I stated she was unable to find any notification in the record. The facility failed to assess and monitor for fever and potential for infection. The Practitioner wrote a progress note on 4/3/24 at 9:51 AM that reflected, This 57 y/o (year old) WM (white male) complains of increasing warmth, tenderness, and erythema in his RLE (right lower extremity). On exam, he has developed a RLE cellulitis (infection of the skin). I ordered Augmentin 875 mg bid (twice daily) for 10 days . 37666 DPS #2 Based on observation, interview and record review, the facility failed to 1). Ensure coordination of Hospice Services for Resident (#24); 2). Ensure wound treatments were completed as ordered for Resident #48 and 3). Ensure an air mattress was functioning properly for Resident #93, resulting in the potential for unmet care needs for Resident #24 and a decline in condition for Resident's #48 and 93. Findings Include: Resident #24 A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #24 indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: stroke with left sided weakness, dementia, chronic ulcer left foot and left calf, chronic kidney disease, heart failure, diabetes, COPD, history of respiratory failure, epilepsy, arthritis, gout, and peripheral vascular disease. The MDS assessment dated [DATE] revealed Resident #24 had moderate cognitive loss with a Brief Interview for Mental Status (BIMS) score of 9/15 and needed assistance with all care. The resident began hospice services 7/25/2023. During a tour of the facility on 4/02/24 at 8:10 AM, Resident #24 was observed lying in his bed. He was awake and alert and readily engaged in conversation. The resident said he had some lower leg pain and a nurse entered and provided pain medication for him. The resident said he was waiting to get out of bed into his wheelchair. He liked to be up for most of the day. A review of the hospice progress notes in the electronic medical record identified the last hospice note dated 1/31/2024. A review of the document section in the medical record revealed several hospice documents with the last being 3/29/2024, but they were not the notes/assessments from the Hospice nurse. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/03/24 at 8:34 AM, during an interview with the Director of Nursing/DON it was reviewed the hospice notes could not be found in the medical record after 1/31/2024. The DON said hospice was supposed to document in the chart and she would check into it. On 4/03/24 at 12:16 PM, Nurse Managers I and J were interviewed related to the missing hospice documents for Resident #24. Nurse Manager J said the resident had previously had a regular hospice nurse, but she left and then the resident didn't have a regular hospice nurse. She said various different hospice nurses saw Resident #24 until recently. Nurse Manager J said the resident now had a new regular hospice nurse. The Nurse Manager said the hospice nurses should have been charting in the medical record. She said she would contact the Hospice company to obtain the Hospice notes. The Nurse Managers said the Hospice nurse usually came in weekly and the nurse aide on Tuesdays. On 4/3/2024 the facility provided hospice documents faxed over from the Hospice company. The documents were not in the resident's medical record to utilize in planning his care. A review of the Care plans for Resident #24 identified the following: I have a terminal prognosis, end of life and am receiving care and comfort only with (Hospice services), r/t (related to) impaired respiratory system, date initiated and revised 7/27/2023 with Interventions including: Work cooperatively with (Hospice services) team to meet my spiritual, emotional, intellectual, physical and social needs, date created 7/27/2023 and revised 8/10/2023. There was no mention of when the Hospice staff were to visit the resident. A review of the facility policy titled, Hospice Services Facility Agreement, date implemented 10/17 and revised 6/23 provided, Policy: It is the policy of this facility to provide and/or arrange hospice services to protect a resident's right to a dignified existence, self- determination and communication with and access to persons and services inside and outside the facility . The facility will collaborate with hospice to ensure that the needs of the resident are addressed . It is the preference of (the facility) that partnered hospice agencies document in the facility electronic health record . Resident #48 A record review of the Face sheet and MDS assessment indicated Resident #48 was admitted to the facility on [DATE] with diagnoses: heart failure, chronic kidney disease, diabetes, osteomyelitis, right leg wound and left great toe wound. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of 15/15 and the resident needed some assistance with care. On 4/02/24 at 9:38 AM, during a tour of the facility, Resident #48 was observed lying in bed. He was observed to have an IV pole/pump near his bedside. He said he was receiving antibiotics for a wound infection. He said he had an infection in his right leg and had previously had surgery there and more recently his foot had rubbed against the foot board of the bed and he got a new sore. He said he was tall and they brought him a longer bed. He said he was comfortable in the longer bed, but his feet were observed rubbing against the footboard. On 4/03/24 at 11:04 AM, upon arriving to Resident #48's room with Nurse G, to observe the nurse providing wound care, the resident said his dressing was not supposed to be changed because the wound care provider changed the order to every other day. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/3/2024 at 11:10 AM, during an interview with Nurse J she said the order was not yet updated, but the resident's dressing was to be changed to every other day. She said she was working on it. The Nurse Manager J said the wound team saw the resident the day prior and looked at the wound and the Nurse Manager said she had to review the orders with the physician prior to changing the times. A record review of the physician orders identified the following: Right leg: Cleanse open areas with 0.125% Dakin's solution Pat dry, apply A&D to leg from knee to toes to promote autolytic debridement, then cover with kerlix. Change daily and as needed, start date 3/27/2024. Left great toe: Cleanse toe with wound cleaner, pat dry, apply gentamicin ointment directly to wound base, cover with non adherent and secure with kerlix. Change twice a day and as needed (don't forget to skin prep tip of toe, start date 3/27/2024. A record review of Resident #48's Treatment Administration Record/TAR for March 2024 revealed the following: The resident's treatment orders to the Left great toe, were changed on several occasions, but there were many instances when the treatments were not completed as ordered: 3/3/2024, 3/6/2024, 3/9/2024, 3/12/2024, 3/13/2024, 3/20/2024 x2 (twice a day treatment), 3/22/2024, 3/26/2024, 3/28/2024. The resident's treatment order to the Right leg, was changed on several occasions, and there were many instances when the treatment was not completed as ordered: 3/1/2024, 3/3/2024, 3/6/2024 x2, 3/9/2024, 3/12/2024, 3/13/2024, 3/20/2024, 3/28/2024. In addition to the left great toe and right leg treatments, the resident had treatments to his heels, bilateral lower extremities and buttocks. There were a total of 27 missed treatments. The nurses were supposed to monitor the resident's IV antibiotic treatment for the wound/bone infection, but the monitoring was not completed 16 times from March 1, 2024-March 31, 2024. A record review of laboratory results for Resident #48 indicated a critically high Vancomycin antibiotic level on 2/27/24. On 3/7/2024 the antibiotic was changed to Ceftriaxone IV daily for osteomyelitis of the left great toe and heel. A review of the laboratory results also identified a wound culture on 7/23 for the left great toe with the organisms proteus mirabilis and pseudomonas aeruginosa. On 4/03/24 at 12:01 PM, during an interview with Nurse Managers I and J it was noted that the last Wound note from the provider was dated 3/17/2024. Both nurses said they rounded with the wound care provider weekly and the provider charted in a different system and printed out the documentation for the facility. It was then reviewed with the facility physician and scanned into the resident's chart. After that the orders and Care Plans were updated. Reviewed with the nurses that there were many missing instances of documentation for Resident #48's wound treatments for March 2024. The resident was not receiving necessary treatments to aid in infection and wound healing. They said the nurses should have documented and if the resident refused the treatment, they should have documented the refusal. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy titled, Wound Treatment Management and Documentation, date implemented 8/11/06 and revised 2/24 provided, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders . Treatments will be documented on the Treatment Administration Record . Resident #93 A record review of the Face sheet and MDS assessment indicated Resident #93 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Quadriplegia, chronic pain, chronic obstructive pyelonephritis, acute respiratory failure, pressure induced deep tissue damage of right ankle, chronic ulcer left foot, history of traumatic brain injury, polyneuropathy and anxiety. 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 needed assistance with all care. On 4/01/24 at 2:19 PM, Resident #93 was observed lying in bed. His head was above the top of the mattress and his feet were almost touching the foot board. The resident said he was 6'3 tall. He said his bed was not long enough and someone brought a bolster to place across the end of the mattress between the footboard. He said sometimes the bolster fell under the bed. It was observed hanging partially below the mattress. He was observed to have an alternating air mattress, but there were no settings on. There were no lights on the mattress pump. It was not on. There was air in the mattress, but it was not alternating. The resident said it didn't always alternate and had been unplugged at times and he was unsure why it was not on. A review of the physician orders identified the following: Skin, Pressure Ulcer & Wound Treatment Protocol- May follow facility protocol, dated 1/5/2024. There was no mention of the alternating pressure mattress/APM on the physician orders. A review of the Care Plans for Resident #93 revealed the following: I am at risk for impaired skin integrity r/t (related to) risk for immobility, nutritionally at risk, risk for shear & friction, history of pressure injuries, require assistance with my ADL's (activities of daily living . increased risk for reopening healed pressure injury located on posterior head (stage 3) and coccyx (stage 2), date initiated and revised 2/1/2024 with Goal: Minimize my risk for further breakdown through the review date, revised 10/18/2023. Interventions included: APM support surface on bed, dated 10/18/2023. There were no instructions for the APM settings. I have actual impairment to skin integrity that were present on admission . Right medial ankle (DTI/deep tissue injury); Right anterior thigh: Shear (healed); Left Distal left foot: DTI; Left distal, Medial great toe: Trauma (healed) . Date initiated 12/11/2023 and revised 12/12/2023 with Interventions including: Continue to follow the Skin at risk interventions, dated 10/18/2023. A review of the Kardex and Treatment Administration Record/TAR dated March and April 2024 for Resident #93, did not identify what settings the alternating pressure mattress pump should be set at. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/03/24 at 10:00 AM, during an observation of the mattress in Resident #93's room with Nurse Manager I, the air mattress had air in it but there were no lights on the mattress pump; no settings were showing. The Nurse Manager said she didn't know why it wasn't on but there was air in the mattress. It was not alternating. The Nurse Manager said she didn't know what the settings should be. Resident #93 had quadriplegia, was unable to reposition self, had a history of pressure ulcers and continued to be high risk for pressure ulcers. A review of the facility policy titled, Skin and Pressure Injury Risk Assessment and Prevention, date implemented 8/11/2006 and revised 2/24, . Residents determined as at risk for developing pressure injuries will have interventions documented in plan of care based on specific factors identified in the risk assessment . Interventions for Prevention and to Promote Healing . Evidence-based interventions for prevention will be implemented for residents who are assessed at risk and/or who have a pressure injury present .Provide appropriate, pressure-redistributing, support surfaces .

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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** 37666 Based on observation, interview and record review, the facility failed to provide Restorative nursing services for one Resident (#60) of 2 residents reviewed for range of motion, resulting in the potential for a decline in condition. Findings Include: Resident #60 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #60 was admitted to the facility on [DATE] with diagnoses: History of a stroke, history of brain and ovarian cancer, Alzheimer's Dementia, heart disease, history of falls with vertebral fracture, anxiety, depression, diabetes and lymphedema. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss and needed assistance with all care. On 4/02/24 at 9:13 AM, Resident #60 was observed sitting in a wheel chair in her room. Her hands were placed on the arm rests of the wheelchair and her right hand was visibly swollen with edema. She was eating breakfast with assistance from Confidential Person O. He said she had a history of a stroke and also had prior brain surgeries. The Confidential Person said Resident #60 had received therapy briefly at the facility. When asked if the resident was receiving Restorative Nursing services, he said he did not know what that was. The Confidential Person was asked if she received any type of assistance with exercises or range of motion and he said she did not. The Confidential Person said he was at the facility for about 11 hours each day and tried to help the resident with care and exercises. On 4/03/24 at 8:34 AM, during an interview with the Director of Nursing/DON, she was asked if the facility provided Restorative nursing services for the resident's and she said the facility did not have a restorative nursing program. She said the nurse aides provided maintenance range of motion, but there was no restorative nurse or restorative nurse aides. The DON said if a resident needed Range of Motion/ROM exercises, the nurse aide would do that. When asked if the facility provided any other restorative services, the DON said they had a walk to dine program. Resident #60 did not walk. A review of the Care plans for Resident #60 provided the following: I have an ADL (activities of daily living) self care performance deficit related to generalized weakness anemia, myopathy . lymphedema . date initiated 1/6/2024 and revised1/26/2024. There was no mention of range of motion exercises or maintenance services. A review of the physician orders did not identify an order for any maintenance or restorative nursing services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/24 at 9:20 AM, interviewed Nurse Manager I related to Resident #60 and restorative nursing services. She said the facility did not have a Restorative nurse or restorative nurse aides. She said residents did not receive restorative nursing services, but they offered maintenance services provided by the nurse aides. Discussed with Nurse Manager I that Resident #60 was not receiving those services and the care plan did not mention it. A review of the facility policy titled, Restorative Nursing Programs, date implemented 5/12 and revised 06/23 provided, Policy: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level . All residents will receive maintenance restorative nursing services .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31197 Based on observation, interview, and record review the facility failed to prevent repeated falls for 1 of 4 residents, Resident #82 (R82) reviewed for falls. The deficient practice resulted in R82 sustaining repeated falls with minor injury over a 60 day period. Findings include: The facility provided a copy of the Fall Reduction Policy dated 2/14/02, last revised date 4/2023 for review. The policy reflected, 2. The nurse will initiate interventions on the resident's baseline care plan, in accordance with the resident's identified risks .a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed . R82 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R82 was admitted to the facility on [DATE] with diagnosis of (but not limited to) Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), dementia (memory and safety impairment), and history of falls. Brief Interview for Mental Status (BIMS) reflected a score of 3 out of 15 which represented R82 had severe cognitive impairment involving short and long term memory deficits. R82 had a resident representative for all medical decision making. During an observation and interview on 4/4/24 at 3:26 PM, R82 was observed seated in the dining room at the table with his back to the TV. R82 was unable to answer any specific questions related to his falls. According to the Activities of Daily Living (ADL) care plan dated 1/11/24 was reviewed on 4/4/24. The care plan reflected, MOBILITY: I ambulate with 1 assist using a 4 wheeled seated walker. Provide cues for redirection as needed. Date Initiated: 1/11/24, Revision on 3/28/24 .TOILETING: I require 1 assist with peri care. Revision on 1/26/24 .TRANSFERRING- 1 assist with walker as I will allow. Revision on 3/29/24 . According to the physician's noted dated 3/27/24 at 11:15 AM, Pt (patient) is ambulatory but has an unsteady gait. He has Parkinson's festinating gait (individuals with Parkinson's disease, marked by short, shuffling steps that begin slowly but increase in rapidity until the walk becomes a half run. The body leans stiffly forward to maintain balance, and there is an associated risk of falling) and falls every time he turns or turns to sit down . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 4/8/24 at 10:39 AM, the Director of Nursing (DON) stated that R82 had a physical therapy (PT) evaluation on 1/12/24 that stated R82 was determined to be unsafe with turning with his walker and recommended 1 assist. The PT evaluation further stated that due to poor safety awareness R82 required the assistance of 1 at all times with mobility. The DON stated that the evaluation on 2/22/24 reflected that R82 requires 1 assist with transfers at all times as he allows because he can not sense chair placement and misses when he attempts to sit. The DON stated the care plan was updated on 3/29/24 (2 months after the evaluation and recommendations were initially made). The facility provided 12 fall investigation reports from 2/20/24 - 4/1/24 for review. On 4/8/24 at 10:39 AM a review was done with the DON. The findings are as follows: -2/20/24 at 2:15 AM, R82 had an unwitnessed fall in his room by his bed. The DON stated the root cause was that he was unsteady and unassisted with new intervention of non-slip strips placed on floor next to bed. According to the 1/12/24 PT evaluation, R82 required assistance with mobility. -2/22/24 at 6:45 AM, R82 was observed in the activity room on the floor with broken glass and an abrasion to his back. The DON stated the root cause was he was attempting to sit in the recliner, missed and fell into the window, breaking it. The new intervention of placing a table in front of the window and to have PT re-evaluate R82 was initiated. The DON stated that PT continued to work with him for 1 month (until 3/27/24) but still remained a 1 assist with mobility, transferring and bathroom use. -2/23/24 at 9:35 AM, R82 was observed on the floor in the dining room. The DON stated he was attempting to self-ambulate and had poor safety awareness. The DON stated the facility did a medication review. -2/28/24 at 4:31 PM, R82 was witnessed attempting to stand from a chair in the dining room when he grabbed his walker and fell backwards, sustaining an abrasion to his back. The DON stated the root cause was attempting to stand without assistance and with the new intervention of a sign placed on his walker to remind him to set the brakes and grab the handles when standing. When asked if staff were to assist resident with transfers and mobility, the DON stated according to the PT evaluations, Yes. -3/4/24 at 8:36 PM, R82 observed on the dining room floor with a skin tear. The DON stated the root cause was attempting to self-ambulate with new intervention to encourage resident to sit in a wide based chair in the dining room. When asked if R82 should have assistance with transfers and ambulation, the DON stated, Yes. -3/23/24 at 7:30 AM, R82 was observed running out of his room, hit the wall and fell to the floor on his stomach. The DON state the root cause was self-ambulating. -3/24/24 at 3:58 AM, R82 was observed on the floor in front of the bathroom door. The DON stated the root cause was he slipped after using the bathroom and the new intervention of placing non-slip grip strips to the floor by the bathroom door. The DON stated that he requires assistance to use the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/25/24 at 1:00 AM, R82 was observed on the bathroom floor between the toilet and the wall, sustaining a skin tear above his eyebrow with steri strips applied to close the wound. The DON stated the root cause was self-transferring to the bathroom with the new intervention of a urinal to be kept at bedside. R82 has severe cognitive impairment and unable to learn new tasks. When asked if there was any evidence that R82 could remember the new urinal and use it effectively, the DON stated, I don't know. -3/28/24 at 4:17 PM, R82 had a witnessed fall in the dining room of the adjoining unit. The DON stated the root cause was attempting to stand on his own and transfer himself and the new intervention not to dine in the adjoining units dining room due to safety issues. -3/29/24 at 9:24 AM, R82 was observed self-ambulating in the hall, staff went to assist him to the activity room and both tripped over a trash can that was moved into the pathway and fell to the floor. The DON stated that R82 was attempting to self-ambulate and there was clutter in the pathway with new intervention of ensuring staff kept pathways and areas clear of clutter. When asked if that was a standard precaution that should always be taken, the DON stated, Yes. -3/30/24 at 10:10 AM, R82 was observed by staff pacing quickly down the hall leaning forward and fell before staff could assist him, sustaining an abrasion. The DON stated the root cause was self-ambulating and a sensor mat was placed on the floor by beside his bed. The DON stated the sensor mat is hooked into the call light system so if he attempts to get up without assistance his call light will light up and there is no sounding alarm associated with it. -4/1/24 at 8:45 AM, R82 was observed by a staff member coming out of another resident's room, self-ambulating at a quick pace without his walker, lost his balance and fell and sustained an abrasion to the knee. The DON stated the root cause was self-ambulating without assistance. The new intervention of reminding him to slow down and have something sturdy to hold on to. The staff stated he nodded his head after being educated. According to his BIM's assessment, R82 has severe short term memory loss and is unable to learn or retain new tasks or skills. According to the progress notes dated 4/7/24 at 8:25 PM, R82 was assisted to the bathroom and returned to his seat in the dining room. Staff walked away and resident attempted to stand and fell in front of his wheelchair. The DON stated this fall has not been thoroughly investigated yet. The facility failed to implement the appropriate safety precaution of 1 assistance for ambulating, transferring and toileting to prevent repeated falls.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 Based on observation, interview, and record review the facility failed to assess and monitor weight changes for 1 of 27 residents (Resident #101) reviewed for weight loss. The deficient practice resulted in Resident #101 (R101) sustaining a significant weight loss. Findings include: R101 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R101 admitted to the facility on [DATE] with diagnosis of (but not limited to) acute gastric ulcer, kidney disease, and blood clot to right leg. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which represented R101 was cognitively intact. During an observation and interview on 4/2/24 at approximately 12:40 PM, R101 was seated in her wheelchair in the dining room. R101 was observed feeding herself and stated the food here is okay. According to the Nutritional assessment dated [DATE] reflected that R101's current body weight was 164.4 lbs. and reported that it was stable for her. The assessment reflected, 16a. My nutrition goals while here are: maintain nutritional status AEB (as evidenced by) weight maintenance . There is no mention of issues with edema or desire for planned weight loss. The weight log was reviewed from admission 2/24/24 - 4/2/24: 2/24/24 164.4 lbs. 2/26/24 164.4 lbs. 2/27/24 164.4 lbs. 3/9/24 155.0 lbs. (9.4 lbs. lost in 10 days, 5.72%) The physician note dated 3/1/24 reflected that R101 complained about pain in her lower extremities due to edema and the plan to start a diuretic for 3 days. The MDS note on 3/1/24 reflects that Lasix 20 mg will be given for 3 days to decrease the edema and pain. Record review of the Care Conference note dated 3/14/24 at 9:47 AM did not reflect the recent weight loss of 9.4 lbs or changes in care planning regarding nutrition, hydration, edema, or weight monitoring. Record review of the Weight Change Note dated 3/27/24 (18 days after the weight loss was noted) reflected and identified weight loss of 9 lb x 1 month and the Plan: Hospital weight was 150 lb and admit weight was 164 lb. Suspect weight fluctuations or inaccuracies, will continue to monitor weight trends weekly . (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 and record review on 4/3/24 at approximately 10:00 AM, Registered Dietitian L stated that she over sees the weight changes in the facility. When asked if it was R101's planned goal to lose weight, RD L stated according to her care plan no. When asked who monitors the weight changes at the facility, RD L stated, I do. When asked who requests for a resident to be reweighed to ensure accuracy of weights, RD L states that she does when indicate. When asked if her 9.4 lbs. weight loss might be an indication, RD L stated there is no specific guidance about that. RD L stated that she found that R101 weighed 150 lbs. in the hospital records, used that as her usual weight and cleared the weight warning she received to notify her. The RD L was asked to review that hospital record with the Surveyor, and it could not be determined if the weight recorded was an actual or a stated weight. RD L also included that R101 was provided a diuretic on 3/2/24, 3/3/24, and 3/4/24 for edema. When asked if the staff reweighed R101 after that to check the effectiveness of the diuretic, RD L stated no. R101 sustained a significant weight loss of 9.4 lbs. lost in 10 days, 5.72%. There was no assessing and monitoring to review after the use of a diuretic (from 3/4/24 - 4/2/24) to ensure accurate weight monitoring.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to follow accepted standards of practice for a peripherally inserted central catheter (PICC line) dressing change for 1 Resident (#405) of 2 reviewed for IV catheters, resulting in a lack of proper hand hygiene, use of a sterile barrier and measurement of the external catheter length, which could result in complications including infection and migration of the catheter. Findings Include: Resident #405 A record review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #405 revealed an admitted to the facility on [DATE] and readmission on 3/9/2024 with diagnoses: Meningitis, brain abscess, brain and lung cancer, diabetes, chronic kidney disease, history of pulmonary embolism. The MDS assessment dated [DATE] indicated the resident had moderate cognitive impairment with a Brief Interview for Mental Status/BIMS score of 11/15. On 4/02/24 at 8:22 AM, during a tour of the facility, Resident #405 was observed to have an IV running via an electronic pump. He said it was an antibiotic for a brain infection. The resident said he had many health issues and had a history of brain surgeries. The resident said he received the IV antibiotic in the morning and evening. The IV dressing on his right upper arm was dated 3/27/2024The IV bag read Ceftriaxone an antibiotic. The IV pump began beeping that there was air in the line. On 4/02/24 a t8:30 AM, Nurse B, said Resident #405's IV antibiotic was just hung for her and she was going in to disconnect it as it ran for 30 minutes and was finished. The nurse was observed to disconnect the IV tubing from the IV and flush the catheter. On 4/03/24 at 8:15 AM, Nurse G was interviewed about Resident #405's IV antibiotic at 7:12 AM that morning. She said the resident also had an IV dressing change to the right arm that day. On 4/03/24 at 10:20 AM, observed the right upper arm PICC line dressing change for Resident #405 by Nurse G. The nurse used a sterile PICC line dressing change kit. She said it included the supplies she needed including a sterile barrier. She did not use the sterile barrier. The nurse donned procedure gloves to remove the old dressing; a transparent dressing and did not perform hand hygiene after removing them and prior to applying the sterile gloves that were in the IV kit. The nurse used the alcohol swabs in included in the IV kit for cleansing around the IV insertion site. The nurse added a CHG (chlorhexidine gluconate) impregnated disk at the insertion cite. When asked about it, Nurse G said she preferred to use the CHG disk and said she wasn't sure if other nurses used the device. There was also an IV securement device on the line. Nurse G was asked about it and stated, It doesn't get replaced. The nurse did not measure the central line length or arm circumference. A review of the physician orders for Resident #405 provided the following: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change Transparent dressing 24 hours post insertion or on admission the (every) week and PRN (as needed), start date 3/28/2024. There was no additional information. A review of the Medication Administration Record and Treatment Administration Record for March and April 2024 for Resident #405 provided the following: Measure external catheter length on admission, with each dressing change and PRN, one time a day every 7 days, start date 3/13/2024. On 4/3/2024 at 10:35 AM, during an interview with Nurse Managers I and J about the IV dressing change for Resident #405, they said the nurse should have washed her hands between gloves and used a sterile barrier. A review of the facility policy titled, Catheter Insertion and Care: Central Venous Catheter Dressing Changes, dated revised July 2016 provided, Central venous catheter dressings will be changed at specific intervals, or when needed, to prevent catheter related infections that are associated with contaminated, loosened, soiled, wet dressings . Change transparent semipermeable dressings at least every 5-7 days and PRN (as needed) . Procedure to remove old dressing: Clean the overbed table with soap and water or alcohol. Place equipment on table. Perform hand hygiene. Wear non-sterile gloves . While stabilizing catheter, remove the dressing in the direction of the catheter insertion . Perform hand hygiene . Procedure to apply sterile dressing . Apply sterile gloves . Don not pick up the catheter with the sterile gloves. The outside of the catheter is not sterile . Clean catheter insertion site with approved antiseptic solution. Allow antiseptic solution to air dry on skin. Do not blow or wave over site . Apply sterile transparent dressing .

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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** 37666 Based on observation, interview and record review the facility failed to ensure unobstructed access to an oxygen concentrator and provide oxygen humidification for one Resident (#44), resulting in the potential for the resident to receive an inadequate amount of oxygen to meet their needs, and discomfort without humidification, which could lead to adverse effects including respiratory distress. Findings Include: Resident #44 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #44 was admitted to the facility on [DATE] with diagnoses: Bipolar disorder, heart disease, Chronic obstructive pulmonary disease, dependence on oxygen, chronic respiratory failure. The MDS assessment dated [DATE] indicated the resident was independent with most care and had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 15/15. On 4/01/2024 at 12:39 PM, during a tour of the facility, Resident #44 was observed sitting on her bed. She had a variety of personal possessions piled on the floor from the wall towards the end of the bed. The resident was wearing a nasal cannula for oxygen, but neither an oxygen concentrator nor oxygen tanks were observed. When asked where the oxygen was, the resident pointed towards the wall. Behind her belongings up against the wall was an oxygen concentrator. The resident was asked what it was set on and she stated, 3 liters, and she pointed at the bedside curtain and stated, You have to go over there to get to it. The oxygen had to be accessed from the other resident's side of the room, because there were too many items stored on the floor in front of it. During the observation of the oxygen concentrator on 4/1/2024 at 12:39 PM, it was observed that the oxygen humidification bottle was empty and the resident stated, It's been empty and my nose has been dry. A Nurse entered the room and brought the resident a new humidification container. On 4/03/24 at 9:15 AM, upon entering Resident #44's room with Nurse Manager F for the North unit, the resident was observed sitting on the edge of her bed and was wearing an oxygen nasal cannula. The Nurse Manager said the resident had a rough night. The resident said she felt a little better that day. The resident's room continued with so much clutter, it was not possible to access the resident's oxygen concentrator from the resident's bedside. The nurse walked to the other resident's side of the room, pulled back the curtain to observe the concentrator, there was a date of 3/27/2024 on the water humidification bottle, about 25% full. The resident said they brought her a full one the day before. The Nurse Manager was asked why the humidification bottle was dated 3/27/24 if it was changed 4/1/2024? She said she didn't know. The oxygen was set at 3 liters. A review of the physician orders for Resident #44 identified the following: O2 via NC (nasal cannula) (1-6 L) for O2 sat <88%, wean for sats > 92% r/t (related to) COPD and chronic respiratory failure with hypoxia, start date 10/27/2023. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Concentrator Maintenance: Wipe down concentrator and rinse external filter. Ensure concentrator is not right up against the wall or curtain, start date 1/24/2024. There was no mention of ensuring humidification was provided on the concentrator to prevent her nose from becoming dry. A review of the Care Plans for Resident #44 provided the following: I have altered respiratory status/difficulty breathing . date initiated 11/17/2022 and revised 12/12/2023. There was no mention of providing humidification on the oxygen concentrator or of ensuring the concentrator was accessible and unobstructed by the wall or objects surrounding it.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 31771 This Citation pertains to Intake MI00142983 Based on interview and record review the facility failed to timely document assessments and findings in the medical record by a medical provider and failed to ensure necessary monitoring, care, and medical treatment was ordered when changes in condition were noted by a Medical Provider but not acted upon for one facility Resident (Resident #85 (R85)) resulting in emergency Intensive Care hospitalization . Findings Include: Review of the electronic medical record (EMR) reflected R85 originally admitted to the facility 8/26/22 and had diagnoses that included: Pseudobulbar Affect (characterized by uncontrolled outburst of laughter or crying), Manic Depression (Bipolar Disease), Dementia and Anxiety. Review of the Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 11/28/23 reflected a score of 2 out of 15 which indicated the Resident was severely cognitively impaired. Section GG of this MDS revealed R85 was functionally able to ambulate independently. Review of the EMR Progress Note dated 2/23/24 at 5:30 PM that R85 was to be transported to the hospital for Altered mental status and Functional decline. Review of the Emergency Medical Services (EMS) document titled Prehospital Care Report Summary (also known as a Run Report) reflected EMS arrived on scene 2/23/24 at 6:04 PM. The vital signs obtained by EMS included a pulse of 135 beats per minute (BPM), respiratory rate of 34 breaths per minute, a blood pressure of 133/106, and a temperature of 103.0 Fahrenheit (F). Review of hospital emergency room records reflected initial vital signs included a core body temperature of 102.74 F, pulse of 141 BPM, and a respiratory rate of 30 breaths per minute. Initial laboratory blood test results included a sodium level of 168 (normal of 134 to 146) which was redrawn to confirm the critically high abnormal value. A white blood count (wbc) lab result of 17.12 (normal range of 4 to 10.8. A high result is indicative of a systemic infection). A urinalysis reflected results that included that the urine specimen of R85 was red and tested positive for blood, white blood cells (infection), and protein. Blood cultures were also obtained and later reflected positive for staphylococcus and gram-positive cocci. Hospital physician documentation included: The facility reported (to the hospital) that R85 had increases in her Zyprexa (an antipsychotic medication) and clonazepam (a benzodiazepine often prescribed for the treatment of panic disorders)) two weeks ago which was thought to be the cause of the (R85) having increased weakness and decrease in mental status over last two weeks. And (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On arrival, (R85) was febrile (fever), tachycardic (high heart rate), had leukocytosis (high white blood cell count), lactic acidosis (potentially life-threatening build up of lactic acid in the blood), an (Acute Kidney Injury) AKI, severe hypernatremia (high sodium blood level), and was minimally responsive. Her (urine) was positive for leukocytes (white blood cells), nitrites, and blood. On exam, (R85) opens her eyes but does not otherwise respond to staff. And Critical Care time (treatment) was required due to the life-threatening nature of this patient's condition . Also On arrival patient appears septic., and She did have strong urine odor . The hospital documentation reflected R85 was admitted to the Intensive Care Unit (ICU) in critical condition with diagnoses that included Severe sepsis, Acute metabolic encephalopathy severe and life-threatening with Hypernatremia secondary to free water loss (dehydration) likely contributing to above, Acute cystitis with hematuria, Acute Kidney injury. Subsequent Hospital Course physician documentation included I am concerned for polypharmacy (taking many prescribed drugs), SS (Serotonin Syndrome (SS) symptoms include high heart rate, high blood pressure, confusion, and high fever as a reaction to medication) or Neuroleptic Malignant Syndrome (NMS) . (NMS is a life-threatening reaction to antipsychotic medications characterized by high fever, altered mental status, high heart rate, rapid breathing and high or low blood pressure). Hold all possible drugs that could contribute (listed are medications R85 had ordered at the facility) And Social work consult to determine if (R85) was left in an minimally responsive state for a week given how dehydrated she was Another physician documented, Social work consult to determine if (R85) was left in a minimally responsive state for a week. If so, concern for neglect . The facility EMR was reviewed for the chronology leading to the admission of R85 to the intensive care unit. Review of the Doctor's Orders for R85 reflected Lorazepam (a controlled substance (benzodiazepine)) was prescribed initially on 8/22/23 by Physician's Assistant (PA) T. Over time this order was renewed or changed multiple times by PA T until 2/7/24. The EMR did not reveal that a Risk versus Benefit had been completed for this Resident to take this medication. Other medications R85 was receiving on 2/7/24 included Zyprexa (prescribed for bipolar disorder), pristique and trazodone (antidepressants), L-methyl folate (for depression or adjunct therapy with antidepressants), and Nuedexa (a central nervous system agent used to treat pseudobulbar affect). (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR reflected on 2/7/24 Lorazepam was discontinued, and clonazepam was ordered by PA T. The EMR did not reflect a Risk versus Benefit was completed for this medication. Also, on this date the order for Zyprexa had changed along with the addition of the Clonazepam. No additional monitoring was ordered by PA T with these medication changes. Review of the EMR vital signs history from 2/7/24 until 2/23/24, when R85 was transported to the hospital, revealed vital signs were only obtained twice (2/11/24 and 2/18/24) Review of the Practitioner Progress Note completed by PA T dated 2/7/24 at 8:05 AM included documentation of the medication changes. However, this note of 2/7/24 also included documentation of vital signs that were taken after this date to include a BP taken on 2/18/24, a pulse and oxygen saturation taken on 2/23/24 and a pain scale result dated 2/16/24. No documentation was found that reflected agreement by the supervising physician regarding the changes in the plan of care made on 2/7/24. Further review of this 2/7/24 note by PA T revealed this entry and two entries dated 2/20/24 by PA T were created and entered as Late entries into the medical record on 2/26/24 which was three days after R85 was admitted to the hospital ICU. This indicated that three assessments that held pertinent information of the status of R85 were not available in the medical record for healthcare providers or the supervising physician. Review of the EMR Nurse Progress Note dated 2/15/24 at 8:46 PM revealed, (R85) noted to be very tired. Refused supper. Refused popcorn and pop for snack which is very unusual, she has a flat affect and poor eye contact. I could not even get her to look at me . Very hard to get her medications in her. She needed help to get them to her mouth and reminders to swallow them. The Late Entry Practitioner Progress Note by PA T dated for 2/20/24 at 8:36 AM (but created 2/26/24 at 8:37 AM) reflected Staff are concerned as (R85) is no longer anxious, restless, or crying but has started to have a blank stare to her the past week or so and she is not verbally communicating very well anymore. The documentation reflected PA T did observe that R85 does have a blank stare to her and has been eating less with meals. And Flat affect with blank stare look to her, generalized weakness, confused and disoriented, and Unsteady gait. Medication orders were changed per this entry. The vital signs documented in this note were from 2/18/24 and 2/23/24. This entry reflects that PA T made direct observations of R85 and had talked with concerned staff. PA T would have reviewed the EMR and been privy to the EMR documentation of 2/15/24 that R85 needed help to get medication into her mouth with reminders to swallow. Despite the changes in condition from 2/7/24 to 2/20/24 AM directly observed by PA T no new vital signs were requested, no lab work or changes in monitoring were ordered. However, medication orders were changed. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The second Practitioner Progress Note by PA T entered as a Late Entry for 2/20/24 at 4:28 PM but created on 2/26/24 at 8:51 AM was reviewed. The entry reflected (R85) was revaluated (sic) later on today to see if there has been any improvement with recent med change, (R85) seems a bit worse. Medication orders again were changed per this PM note. Despite the changes in condition documented at 8:36 AM this day and then documenting at 4:28 PM that R85 was again observed and was worse PA T took no action to address the noted decline and did not give nursing staff direction on monitoring or guidance for a Resident manifesting a significant change of condition. The documentation of the medical record did not indicate that PA T sought guidance from the supervising physician. The medical record did not reflect any involvement by the supervising physician or that the supervising physician was aware of the Residents condition or the absence of pertinent information missing from the medical record during the period prior to the hospitalization of R85. The document titled Medical Director Agreement, a written agreement by the physician group providing services and the facility, dated 10/19/23 was reviewed. The agreement reflected. (a) Medical Director will provide services to the Facility provided by a medical director in the nursing home industry as required by all laws and regulations including implementation of resident care policies and coordination of medical care within the facility. (b) Resident care policies include, but are not limited to, . physician privileges and practices, responsibilities of non-physician health care workers, emergency care, medical documentation . and overall quality of care. (c) Coordination means that the Medical Director is responsible for assuring that the Facility is providing appropriate care as appropriate to resident medical conditions. This involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and the medical care of residents . On 4/8/24 at 10:24 AM an interview was conducted with Medical Director (MD) W. MD W reported that PA T is not longer at the facility and that medical record documentation was a factor in this decision. MD W reported he did speak with a physician from the hospital and that the hospital felt that R85 had been neglected. MD W reported that R85 displayed the biggest decline on the day the Resident was transported to the hospital. However, in review of the medical record no documentation was found that revealed any change or decline earlier in the day on 2/23/24 not included in this report. On 4/4/24 at 3:27 PM an interview was conducted with the Director of Nursing (DON). The events of care provided to R85 from 2/7/24 up to the Residents transport to the hospital were reviewed. The DON reported PA T should have ordered increased monitoring after the 2/7/24 evaluation. The DON reported that she expects a note to be in the medical record within 24 hours. The DON stated I have no idea why (PA T) made two notes on (2/20/24). It just makes no sense to me. Regarding the Late Entry by PA T of 2/20/24 at 8:36 AM. The DON reported that if PA T thought it was alarming enough to put in a note that R85 had a blank stare, that it should have been acted upon. The DON had indicated that she had no further documentation. As of survey exit no further documentation was provided.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 31771 Based on observation, interview, and record review the facility failed to publicly post nurse staffing data. Findings: On 4/8/24 at 11:20 AM a review of facility posting was conducted. During the review the staff posting could not be located. On 4/8/24 at 11:30 AM Unit Manager (UM) I was asked where the daily staff posting data is located. UM I took the surveyor to the main Nurses Station where a binder titled (facility name) Schedule Book was located. Inside the book, along with the staff schedule was the completed daily staff posting form for 4/8/24. UM I was asked if this is posted in the facility. UM I stated No and indicated the daily staff posting is kept in the facility Schedule Book. The book cover did not reflect that the daily staff posting was inside the binder or that public information was contained within.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to provide medically-related social services for 1 of 27 residents (R98), resulting in R98 not having current up-to-date guardianship documentation. Findings include: A review of R98's Admission Record, dated [DATE], revealed R98 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included frontal lobe malignant neoplasm (brain cancer), cerebral edema (brain swelling), convulsions, delusional disorder, pulmonary embolism (blood clot in the lungs), and aphasia (difficulty verbally communicating). In addition, R98's Admission Record revealed Guardian (GRD) K was R98's primary contact for healthcare needs and guardian. A review of R98's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 10 which revealed R98 was moderately cognitively impaired. A review of R98's Order Regarding Appointment of Temporary Guardian of Incapacitated Individual, dated [DATE], GRD K was appointed as R98's guardian due to R98 did not have a guardian, an emergency exists, and no other person appears to have the authority to act in the circumstances. A showing has been made that the individual is incapacitated. In addition, R98's Order Regarding Appointment of Temporary Guardian of Incapacitated Individual revealed the temporary guardianship order expired on [DATE]. A review of R98's Durable Power of Attorney (DPOA) for Health Care documentation, dated [DATE], revealed GRD K was designated as R98's DPOA in the event R98 could no longer participate in treatment decisions. A review of R98's medical record failed to reveal any documentation that two physicians (or a physician and a psychologist) had determined R98 could no longer make medical decisions. In addition, R98's medical record failed to reveal that R98's medical decision making status (mental capacity) had changed from what it was at the time of the temporary guardianship order. Therefore, R98's DPOA could not be activated and the only valid way GRD K could make medical decisions for R98 would be through the powers granted through the temporary guardianship order that had expired. During an interview on [DATE] at 11:30 AM, the Nursing Home Administrator (NHA) was notified R98's Order Regarding Appointment of Temporary Guardian of Incapacitated Individual that was in their medical record was expired and a copy of a current order for guardianship (e.g., Letters or Guardianship or another updated and currently valid temporary guardianship order) was requested from the NHA. During a second interview on [DATE] at 01:36 PM, the NHA stated the Order Regarding Appointment of Temporary Guardian of Incapacitated Individual, dated [DATE], that was in R98's medical record was the most current guardianship order that the facility had for R98.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 31771 This Citation Refers to Intake Number MI00142983 Based on interview and record review the facility failed to properly monitor for psychotropic medication side effects and failed to identify and report signs that resulted from medication changes for one Resident (Resident #85 (R85)). Findings: Review of the electronic medical record (EMR) reflected R85 originally admitted to the facility 8/26/22 and had diagnoses that included: Pseudobulbar Affect (characterized by uncontrolled outburst of laughter or crying), Manic Depression (Bipolar Disease), Dementia and Anxiety. Review of the Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 11/28/23 reflected a score of 2 out of 15 which indicated the Resident was severely cognitively impaired. Review of the EMR Progress Note dated 2/23/24 at 5:30 PM that R85 was to be transported to the hospital for Altered mental status and Functional decline. Review of the Emergency Medical Services (EMS) documentation revealed vital signs included a pulse of 135 beats per minute (BPM), respiratory rate of 34 breaths per minute, a blood pressure (BP) of 133/106 and a temperature of 103.0 Fahrenheit (F). Review of hospital emergency room records reflected initial vital signs included a core body temperature of 102.74 F, pulse of 141, and a respiratory rate. of 30 breaths per minute. emergency room documentation reflected, On arrival, (R85) was febrile (fever), tachycardic (high heart rate), . and was minimally responsive .On exam, (R85) opens her eyes but does not otherwise respond to staff. Hospital physician documentation included: The facility reported (to the hospital) that R85 had increases in her Zyprexa (an antipsychotic medication) and clonazepam (a benzodiazepine often prescribed for the treatment of panic disorders)) two weeks ago which was thought to be the cause of the (R85) having increased weakness and decrease in mental status over last two weeks. And Critical Care time (treatment) was required due to the life-threatening nature of this patient's condition . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent Hospital Course physician documentation included I am concerned for polypharmacy (taking many prescribed drugs), SS (Serotonin Syndrome (SS) symptoms include high heart rate, high blood pressure, confusion, and high fever as a reaction to medication) or Neuroleptic Malignant Syndrome (NMS) . (NMS is a life-threatening reaction to antipsychotic medications characterized by high fever, altered mental status, high heart rate, rapid breathing and high or low blood pressure). Hold all possible drugs that could contribute (listed are medications R85 had ordered at the facility) On 4/03/24 at 11:48 AM review of the EMR did not reveal a Risk versus Benefit for lorazepam when first ordered on 8/22/23 but discontinued on 2/7/24. Also, on 2/7/24 clonazepam was ordered but no Risk versus Benefit was found in the EMR A request was submitted to Regional Nurse Consultant (RNC) P for this information. O4/03/24 at 12:08 PM RNC P provided a Risk versus Benefit for Clonazepam for R85 dated 3/2/24 which is after the original order date of 2/7/24. No Risk versus Benefit was available for the lorazepam. Other medications R85 was receiving on 2/23/24 included Zyprexa (prescribed for bipolar disorder), pristique and trazodone (antidepressants), L-methyl folate (for depression or adjunct therapy with antidepressants), and Nuedexa (a central nervous system agent used to treat pseudobulbar affect). During an interview conducted 4/8/24 at 11:01 Social Worker (SW) S she initiates the Risk and Benefit form in the EMR anytime a resident has a Doctor's Order for a hypnotic, antidepressant, antipsychotic, anxiolytic, or mood stabilizer. SW S reported that she missed the Ativan order and did not catch the Doctor's Order for the clonazepam for R85. Therefore, Risk versus Benefit forms were not completed when R85 started on these two medications. Review of the EMR Progress Note dated 2/15/24 at 8:46 PM revealed, (R85) noted to be very tired. Refused supper. Refused popcorn and pop for snack which is very unusual, she has a flat affect and poor eye contact. I could not even get her to look at me . Very hard to get her medications in her. She needed help to get them to her mouth and reminders to swallow them. No documentation of vitals signs or further assessment or monitoring were located regarding this entry. The Practitioner Progress Note by PA T dated for 2/20/24 at 8:36 AM reflected Staff are concerned as (R85) is no longer anxious, restless, or crying but has started to have a blank stare to her the past week or so and she is not verbally communicating very well anymore. The documentation reflected PA T did observe that R85 does have a blank stare to her and has been eating less with meals. And Flat affect with blank stare look to her, generalized weakness, confused and disoriented, and Unsteady gait. Medication orders were changed per this entry. No vital signs requested or was additional monitoring ordered at this time. The second Practitioner Progress Note by PA T for 2/20/24 at 4:28 PM was reviewed. The entry reflected (R85) was revaluated (sic) later on today to see if there has been any improvement with recent med change, (R85) seems a bit worse. Medication orders again changed per this PM note No additional monitoring was ordered at this time. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for February 2024 for R85 reflected four separate sections for monitoring for adverse side effects of medications. One section each was established for an anti-depressant, anti-psychotic, anxiolytic, and one for General Anticholinergic effect. Each section was documented in three times a day. A positive finding required this to be noted in the MAR with a Nursing Progress Note entry. Side effects to be observed for and documented included, altered mental status, excessive sedation, dry mouth, confusion, drowsiness, lethargy, irregular heartbeat/pulse. Review of these four sections of monitoring reflected staff initials of no abnormal findings despite the Progress Note entry of 2/15/24 and staff reports of concerns alleged by PA T on 2/20/24. No further Progress Notes regarding the mental or physical status of R85 are documented until the Resident was transported by EMS to the hospital where she was admitted in critical condition. On 4/4/24 at 3:27 PM an interview was conducted in an office with the Director of Nursing (DON). The DON reported that increased monitoring of R85 should have been ordered after the 2/7/24 evaluation by PA T. After reviewing the entries of 2/20/24 by PA T the DON reported that the PA thought it was alarming enough to put in a note that the abnormal observations of R85 should have been acted upon. The DON reported that nurses should have acted upon the findings that were documented in the EMR on 2/15/24 (lethargy, refusing food, helping R85 get medication into her mouth with reminders to swallow). The DON reported an expectation that vital signs would have been taken and the medical provider contacted. The DON reported she had no further documentation or information to provide. No further documentation was provided prior to survey exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to: 1) safeguard the confidentiality of medical records for 1 of 27 facility residents [R25) and 2) maintain complete, accurate, and timely medical records for 3 of 27 residents (R70, R85, and R98), resulting in inaccurate medical records and delayed entry of vital medical record information by the physician provider, the potential for providers not having an accurate and complete picture of the resident's stay at the facility, the potential for unauthorized access to resident medical records, and the potential for the loss of resident privacy and confidentiality of their personal health information. Findings include: R25 During an observation on [DATE] at 11:00 AM, the computer screen on top of the North [NAME] Medication Cart was observed open to R25's electronic Medication Administration Record, (e-MAR), specifically to the medication diclofenac sodium. R25's personal and health identifying information (i.e., picture, name, medical record number, physician name, room number, and age) were visible beside the open medication screen (which was a pulled up window over R25's other medications and to the right of R25's visible personal medical information). Anyone walking by the medication cart could have stopped and accessed all of R25's medications and/or medical records if they closed out the medication window. There were not any staff in sight of the medication cart at the time of the initial observation. During an observation and interview on [DATE] at 11:05 AM, Registered Nurse (RN) M walked up to the North [NAME] Medication Cart as the surveyor was reviewing R25's open e-MAR. She stated she should not have left the computer screen on top of the medication cart open to R25's e-MAR. When RN M walked up to the medication cart she asked the surveyor, What's the problem. Is it because I left the screen open to a medication and the screen was not hidden? She stated she should not have left the computer screen open, but I feel I did nothing wrong. The drug information was visible, but I believe the resident's name was covered [by the open medication screen]. The surveyor mentioned that R25's name, picture, medical record number, physician name, age, and room number were visible beside the open medication screen and RN M stated she could see that also. However, RN M still insisted that she did not do anything wrong because her perception was R25's information was not visible to anyone walking by the medication cart due to it being in a gray/lighter color than the medication screen. During an interview on [DATE] at 11:15 AM, RN N stated she logs off her computer screen and folds the computer screen down (the computers are laptops) so no one can access it without authorization and to protect the resident information. She stated, Some people know how to open the screens and log on with a push of a button. Then they can access any resident records. That's why I also close the computer (fold the screen down). A review of the facility's HIPAA (Health Insurance Portability and Accountability Act) Sanctions policy, dated [DATE], revealed, 2. All employees are expected to comply with all policies and procedures regarding the protection of personal identifiable health information of our residents . 6. Examples of violations include, but are not limited to . e. Leaving a secured application unattended while logged on . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R70 A review of R70's Admission Record, dated [DATE], revealed R70 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 70's Admission Record revealed multiple diagnoses that included depression, anxiety, and alcohol dependence with alcohol-induced persisting dementia. In addition, R70's Admission Record revealed he had a legal (court appointed) guardian. A review of R70's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R70 had short-term and long-term memory problems with severely impaired cognitive decision-making skills. A review of R70's Letters of Guardianship, dated [DATE], revealed Guardian (GRD) A was appointed R70's guardian. A review of R70's Risk vs. Benefit/GDR (Gradual Dose Reduction) Form, dated [DATE], revealed a name was listed that was not R70's guardian's name as the person that was informed on [DATE] of the indications (reasons) for use and risks vs. benefits of the use of Zyprexa (olanzapine). During an interview on [DATE] at 11:00 AM, the Nursing Home Administrator (NHA) was informed about the name listed on R70's Risk vs. Benefit/GDR Form as the one who was informed of the indications for use and the risks vs. benefits of the use of Zyprexa and was asked if he knew who the person was. He stated he did not know, but would find out. During an interview on [DATE] at 11:14 AM, the Director of Nursing (DON) stated she did not know who the person was that was listed on R70's Risk vs. Benefit/GDR Form as being informed about R70's Zyprexa indications for use and risk vs benefits of use. She stated she would find out and get back to the surveyor. During a second interview on [DATE] at 02:15 PM, the DON stated they do not know who the person was that was listed as being informed about R70's Zyprexa on R70's Risk vs. Benefit/GDR Form, dated [DATE]. She stated, It was a typo even though the two names (the one listed on R70's form dated [DATE] and R70's guardian's name) were not close in spelling. The DON stated when the form was filled out, they meant to put GRD A's name on it, but instead put the other name on it. R98 A review of R98's Admission Record, dated [DATE], revealed R98 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included frontal lobe malignant neoplasm (brain cancer), cerebral edema (brain swelling), convulsions, delusional disorder, pulmonary embolism (blood clot in the lungs), and aphasia (difficulty verbally communicating). A review of R98's Medical Treatment Decision Form, dated [DATE], revealed R98 was a CPR (cardiopulmonary resuscitation) Full resuscitation. The Signature of Resident/ or Legal Representative line had via phone c/ (with) guardian written on it. However, the name of the guardian was not noted and there was not any signature of a guardian on the form that could have been attained at a later date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:30 AM, the Nursing Home Administrator (NHA) was notified that R98's Medical Treatment Decision Form had via phone c/ guardian written on the signature line, but no name was listed. The NHA stated that the facility staff member(s) who completed the form should not have just written on the signature line via phone c/ guardian but should have included the guardian's name since the Medical Treatment Decision Form is an official, legal document. The NHA further stated that the guardian should have come in, or had the form mailed or faxed to them and returned, after the staff received verbal confirmation over the phone and the guardian should have signed the form since it was a legal document. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing (i.e., medical) practice . Documentation of nurses' (or other health professional) work is critical as well for effective communication with each other and with other disciplines. It is how nurses (or other health professionals) create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's (or other health professionals) contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care . Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses (or other health professionals) in all roles and settings . (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org). 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- Assessments; Clinical problems; Communications with other health care professionals regarding the patient; Communication with and education of the patient, family, and the patient's designated support person and other third parties; Medication records (MAR); Order acknowledgement, implementation, and management; Patient clinical parameters; Patient responses and outcomes, including changes in the patient's status; and Plans of care that reflect the social and cultural framework of the patient . 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). 31771 R85 Review of the electronic medical record (EMR) reflected R85 originally admitted to the facility [DATE] and had diagnoses that included: Pseudobulbar Affect (characterized by uncontrolled outburst of laughter or crying), Manic Depression (Bipolar Disease), Dementia and Anxiety. Review of the Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated [DATE] reflected a score of 2 out of 15 which indicated the Resident was severely cognitively impaired. Section GG of this MDS revealed R85 was functionally able to ambulate independently, could eat on her own with set- up assistance, and could toilet independently. (continued on next page)

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	235357	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Physical Rehab Ctr of Belding	414 E State St Belding, MI 48809

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EMR Progress Note dated [DATE] at 5:30 PM revealed that R85 was to be transported to the hospital for Altered mental status and Functional decline. The EMR was reviewed for the chronology of care and treatment leading to the hospital evaluation of R85. The review revealed three Practitioner Progress Notes by Physician Assistant (PA) T labeled as Late Entry with one dated [DATE] and two entries dated [DATE]. Further review revealed these assessments were not entered into the medical record until [DATE] which was three days after R85 was admitted to the hospital. The EMR Practitioner Progress Note by PA T entered as [DATE] at 8:05 AM was created on [DATE] at 8:06 AM and contained an assessment and pertinent information on psychotropic medication changes. The two EMR Practitioner Progress Notes by PA T dated [DATE] and timed as 8:36 AM and 4:28 PM were not created until [DATE]. Both entries contained information regarding a significant change in condition to include medication changes and data that R85 had a blank stare, was confused and disoriented, and had an Unsteady gait among other notable changes from [DATE]. The latest entry of [DATE] also reflected that R85 was worse than the earlier evaluation that same day. The EMR documentation of the created date of [DATE] reflects that the three Practitioner Progress Notes by PA T contained critical health information not available for review by other medical providers, nursing staff, social workers, or the interdisciplinary team (IDT). Had this information been available to these disciplines the potential exists that the decline and subsequent hospitalization of R85 could have been avoided. On [DATE] at 3:27 PM an interview was conducted in the office with the Director of Nursing (DON). The DON reported she would like a note (documentation) to be in (the EMR) right away. The DON reiterated that I want to see a note within 24. The DON reported that PA T is no longer at the facility and that timeliness of documentation was a contributing factor.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31197 Based on observation, interview, and record review the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) committee that identified care concerns, respond to deficiencies, and maintain compliance for all residents that resided at the facility. The deficient practices resulted in repeated identified deficiencies from the previous annual survey, and undesired outcomes for residents. Finding include: According to the CMS-2567 dated 2/17/23 with a date of correction of 3/17/23 the facility was found to be out of compliance with F-679 meeting the activity needs/interests of residents when the residents of the memory care unit were observed sitting around with lack of meaningful engagement. According to the plan of correction, the staff were educated to provide individual activities according to the resident assessment. The policy was reviewed. The activity calendars were updated and posted monthly. Results were to be presented by the Activities Director/designee to the Administrator who would present results at QAPI meeting monthly. Results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. The administrator was responsible for attaining and maintaining compliance. During the annual survey the Surveyors observed residents on the memory care unit with no purposeful/meaningful engagement. Some residents were observed sitting and staring off. The activities calendar reflected no programing or offerings on weekends. Records were reviewed for Resident #53 (R53) and R82 and did not reflect routine/daily documentation for group activities or 1:1 activity. During an interview and record review on 4/8/24 at approximately 2:50 PM, the Director of Nursing (DON) was made aware of the surveyors' observations and record review related to activities on the memory unit. When asked if the facility QAPI committee was aware of the repeated deficient practice, the DON stated the facility went through some staff cuts and the QAPI committee felt it was meeting the expectation of the regulation, therefore there were no performance improvement plans in place to address the concern identified by the Surveyors. According to the CMS-2567 dated 2/17/23 with a date of correction of 3/17/23 the facility was found to be out of compliance with F-684 quality of care concerns such as identifying a significant weight loss, ensuring nutritional needs were not met, assessing, monitoring, and reporting changes to the physician. According to the plan of correction the DON educated the staff on the Weight Monitoring Policy and the Nutritional Assessments Policy. Audits were done and reported to the QAPI committee. Results and system components will be reviewed by the QAPI committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. The administrator was responsible for attaining and maintaining compliance. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the annual survey the Surveyors' found evidence of quality of care concerns for R85 when a change in condition was not identified that resulted in a hospitalization , R76 had fever reported to the physician and the staff failed to continue to assess and monitor for infection, R48 had an air mattress for his impaired skin that staff failed to ensure was on and operating as ordered, R24 had no evidence of coordination of care with hospice since 1/24/24, and R101 sustained a significant weight loss when her 5.72 % weight loss was not assessed or monitored. During an interview and record review on 4/8/24 at approximately 2:50 PM, the DON was made aware of the observations, interviews and record reviews done during the annual survey with the findings. When asked if the facility QAPI committee was aware of the repeated deficient practice, the DON stated they were not. These deficient practices were identified on the previous annual survey, the facility was able to regain compliance on 3/17/23 but did not maintain sustained compliance.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39083 Based on observation and interview, the facility failed to maintain ventilation, resulting in odors and uncirculated air, affecting all residents' in the North Hall's. Findings include: On 4/1/24 at 9:43 AM, the North halls were observed to have stagnant, humid air. The [NAME] hall shower room exhaust vent was tested using a paper towel to test the exhaust function and no suction was observed. On 4/1/24 at 9:45 AM, the bathroom of resident room [ROOM NUMBER] was tested using a paper towel and no suction was observed from the vent. On 4/1/24 at 9:48 AM, the bathroom of resident room [ROOM NUMBER] was tested using a paper towel and no suction was observed from the vent. During an interview on 4/1/24 at 10:14 AM, Maintenance Director R was queried on the frequency of preventative maintenance inspections for the ventilation system and stated that they are inspected twice a year. Maintenance Director R continued to say that the North halls are equipped with a rooftop unit separate from the South Halls.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 31771 Based on interview and record review the facility failed to ensure Certified Nurse Aides had completed a minimum of twelve hours of in-service training annually. Findings: On 4/8/24 at 9:34 AM the Director of Nursing (DON) was asked to provide documentation of completed annual in-service training for Certified Nurse Aide (CNA) D, CNA E, CNA Q, and CNA X. Review of the information provided by the facility reflected CNA D had 5.25 hours of training at the start of this survey, 4/1/24, to include abuse training. Dementia training was not completed at the onset of the survey. Review of the information provided reflected CNA E had a hire date of 6/5/23 and had no record of in-service hours to include no record of Abuse training at the start of this survey. Review of the information provided reflected CNA Q had 1 hour of in-service training at the start of this survey. Abuse training was not listed, and Dementia training was not initiated until after the onset of the survey. Review of the information provided by the facility reflected CNA X had 2 hours of training at the start of this survey. Abuse training was not listed, and Dementia training was completed after the onset of the survey. On 4/8/24 at 2:51 PM the DON reported that Human Resources tracks employee in-service training. The DON indicated that the information that was provided is all that is available.