STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235359	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faith Haven Senior Care Centre	6531 W Michigan Avenue Jackson, MI 49201

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observations, interviews and record review, the facility failed to answer call light and provide timely care and services to one residents (R67) of one reviewed, resulting in frustration and embarrassment. Findings included: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R67 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included urinary tract infection, multiple sclerosis(chronic disease of the central nervous system that causes muscle weakness and vision changes), and anxiety disorder. The MDS reflected R67 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact, and she required one person assist with transfers, ambulation and toileting. During an observation and interview on 1/02/25 at 11:42 AM, R67 was laying in bed with call light in reach and appeared able to answer questions without difficulty. R67 complained of having her call light on for over 30 minutes and urgently needing to use the bathroom. R67 said they just do not have enough help. R67 said this happens at least 5 to 7 times a week. R67 said she knows when she has to urinate but sometimes they make her wait to long and has accidents. The red light on the wall for the call light was illuminated. This surveyor exited room and did not see or hear call light or alarms in hall. During an observation on 1/02/25 at 11:54 AM, R67 call light remained on when dietary staff entered room with meal tray. R67 overheard telling staff call light was on because she needed to be changed. Dietary staff was overheard telling R67 she would left staff know exited room and continued to pass meal trays to other resident rooms. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/02/25 at 11:57 AM, Certified Nurse Aid (CNA) U reported started shift at 6:00am and was assigned to R67 today. CNA U reported the facility uses a pager system for call lights that each staff have on person that sound with call lights(no sound could be heard). CNA U she did not have a pager on at the time because, and stated, I hit the floor running(current time 11:57 a.m.). CNA U reported staff can check call lights by going to 300 Nurse station and reviewing computer screen for call lights as well(300 hall nurse station was located at the end of the 300 hall.) CNA U continued to passing meal trays to other rooms. This surveyor immediately observed call light monitoring system at the 300 Nurse Station that reflected R67 call light remained on at 11:59 a.m. and was on at 11:42 a.m.(16 minutes). Dietary staff was overheard reporting to CNA U that R67 needed assistance with changing and CNA U entered R67 room and turned of call light at 12:00 p.m. Review of the Care Plans, dated 10/25/24, reflected R67 required one person physical assistance with transferring. Review of Resident Council Meeting minutes and Grievance Log, dated 6/2024 through 12/2024, reflected call light response time concerns reported in past three of six months. During an interview on 1/3/25 at 4:50 p.m., Clinical Care Coordinator (CCC) V reported oversees the 200 and 300 hall residents. CCC V reported CNA staff use pagers for resident call light system. CCC V reported would expect CNA staff to wear pagers at all times and reported was not aware staff did not have pagers on 1/2/25. CCC V reported residents occasionally complain of slow response times to call lights but nothing that she could recall in past 2 months. During an interview on 1/6/25 at about 1:35 p.m., Nursing Home Administrator (NHA) A reported facility does not ability to perform call light audits. NHA A reported facility uses pagers system to answer call lights and would expect staff to have pagers on and functioning at all times. NHA A reported was not aware that some staff were not wearing pagers on 1/2/25. Review of the new admission packet provided to all residents on admission included, KNOW YOUR RIGHTS--Your Medicaid Care and Coverage in A Nursing Facility, DCH[Department of Community Health] 0731 (10/13) . The documents included, Quality of Your Medical Care. You have the right to receive necessary nursing, medical and social services to reach and maintain the highest practicable physical, mental and social well being, as determined by the comprehensive assessment and care plan. These services must be given in a confidential and dignified manner that meets your treatment and personal needs .

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 27306 Based on interview and record review, the facility failed to ensure that grievances were promptly resolved and/or responded to in a timely manner for 5 of 5 residents that participate in Resident Council (RC) meetings. Findings include: On 01/03/25 11:05 AM during the confidential group meeting, RC members reported management talks about fixing problems but does not put everything in writing and does correct or communicate updates on issues. When asked for the RC members to clarify they reported they talk about cold coffee month after month and offer solutions but it falls on deaf ears. One of the RC members reported that the Nursing Home Administrator (NHA) A attended the December 2024 meeting and the Council requested to discuss the coffee issue. The participants reported NHA A stated someone would start doing test trays to obtain coffee temperatures. The response of the taking a test tray added to the RC members frustration as they have consistently reported the coffee temperatures were cold, they reported they don't need NHA A to take coffee temperatures to validate their concern, they know its cold, they want a resolution. Five of 5 RC members/group participants also reported they have requested for several times for a different cable package (that includes ABC) along with a television in the main dining room. In which they reportedly were told months ago that management was waiting for big screen televisions to go on sale. Review of the facility RC minutes dated 6/18/24 reflected in part the residents requested a different cable provider, they voiced they currently were unable to receive the ABC network on their televisions and wanted additional television channel options that included the ABC network on their televisions. Review of the 7/23/24 RC Minutes reflected in part, residents had a concern related to cold coffee temperatures. Review of the 8/20/24 RC Minutes reflected in part, residents had a concern related to cold coffee temperatures. Review of the 9/24/24 RC Minutes reflected in part, residents had a concern related to cold coffee temperatures and it was requested to have a television placed in the main dining room and more television channels. The facility did not have a monthly RC Meeting in October 2024. Review of the RC minutes dated 11/26/24 revealed follow up from the 9/24/24 RC meting {sic} Mgt (Management) looking for a TV for dining room and watching holiday sales. and carafe cannot be temperature controlled. Review of the 12/17/24 minutes reflected no new concerns, It was explained to residents why a carafe cannot be used because of various {sic} temps. (no further explanation was documented as to why carafes cant be used.) (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the grievance form responses/resolutions were reviewed and none of the responses over the 6 month time frame addressed the television in the dining room, additional television channels, or cold coffee. On 01/06/25 at 09:14 AM, during an interview with NHAA she reported the process of RC was that minutes were to be reviewed as an interdisciplinary team the day after the meeting and all concerns were transferred to resident assistance/concern forms and then given to the discipline in charge. When queried why there were zero assistance/concern forms related to cold coffee NHA A stated it was addressed in June of 2024- review of that form indicated an issue with hot water, not coffee. NHA A was asked to explain why the concern was repeated month after month and why there was no assistance/concern form the the issue, NHA A stated the Dietary Manager was to follow up and she will attempt to get the Dietary Managers documentation to that effect. When queried why there was no assistance forms to address the cable package, and the television in the dining room concerns/requests brought forth by the RC members, NHA A stated she was not sure if she wanted a television in the dining room, when queried why that was not communicated to the RC members opposed to the November minutes that reflected you were waiting for a sale NHA A did not offer an explanation, when queried about the cable provider and or cable packages - NHA A stated they were looking at cable packages currently. Of note, the RC members initially made this request (with no documented response) 7 months prior, and NHA A provided no documented responses related to the Dietary Manager following up on the chronic complaint of cold coffee temperatures. According to the facility Policy titled Resident Concern dated 8/31/15 with a revision date of 2/26/19. The policy revealed time frames in part, for responding to concerns were as soon as possible but within 15 days and a written response was to be provided as soon as possible but no later that 30 days.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for three (R64, R66, R89) of 18 reviewed. Findings include: Resident #66 (R66) Review of the medical record revealed R66 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder. The MDS with an Assessment Reference Date (ARD) of [DATE] revealed R66 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Preadmission Screening/Annual Resident Review (PASARR) Level I Screening revealed no mention that R66 had a diagnosis of schizophrenia. The MDS assessments with ARDs of [DATE] and [DATE] revealed R66 was not coded as having a diagnosis of schizophrenia. Review of R66's diagnosis list revealed a diagnosis of schizophrenia was added on [DATE]. Review of the MDS with an ARD of [DATE] revealed R66 was coded with a diagnosis of schizophrenia. In an interview on [DATE] at 9:15 AM, Social Work Director (SWD) J reported R66 had a diagnosis of bipolar disorder. SWD J reported they were not sure why R66 had a diagnosis of schizophrenia listed in their medical record. In an interview on [DATE] at 11:57 AM, Unit Manager (UM) K reported they did not know why R66 had a diagnosis of schizophrenia listed in their medical record or why it was coded on the MDS. In an interview on [DATE] at 3:25 PM, Regional Clinical Director (RCD) F reported R66's diagnosis of schizophrenia and MDS coding of schizophrenia was inaccurate. 45038 Resident #64 (R64) Review of the medical record revealed R64 was admitted [DATE] with diagnoses that included peripheral vascular disease (PVD), type 2 diabetes mellitus, atherosclerotic heart disease (buildup of cholesterol plaque in artery walls), hypertension, history of heart attack, depression, osteoarthritis (type of arthritis that occurs when flexible tissue at the end of bones wears down) bilateral hips, asthma, and schizoaffective disorder bipolar type. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R64 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on [DATE] at 01:36 p.m. R64 was observed lying down in bed. R64 explained that she has stayed at the facility several different times and that after the previous stay she was discharged home. R64 explained that she recently returned to the facility after a hospital stay. Review of R64's medical record revealed the most recent Minimum Dat Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed section I-Active Diagnoses, subsection 15900-Bipolar had been document no and subsection I6000- Schizophrenia, had been documented as yes. Review of R64's medical diagnoses record revealed the diagnoses of schizoaffective disorder bipolar type, which had been added to the diagnoses record on [DATE]. Review of R64's hospital discharge records, dated [DATE] did not demonstrate a discharge diagnoses of schizoaffective disorder bipolar type. Review of R64's Preadmission Screening (PAS) Annual Resident Review (ARR), hospital exemption discharge date d [DATE], revealed yes-the person has a current diagnosis of mental illness, yes-the person has received treatment for mental illness, yes-the person has routinely received one or more prescribed antipsychotic or antidepressant medication within the last 14 days. The same PASARR, dated [DATE] revealed documentation that stated, explain any yes - bipolar . In an interview on [DATE] at 02:54 p.m. Social Worker (SW) J explained that she is responsible to review that residents that are receiving psychotropic medication to ensure that they have the appropriate diagnoses for the use of that type of medication. SW J explained that she is not responsible to verify the diagnoses with previous hospital records and only verifies those diagnoses by reviewing the resident's diagnoses record in the chart. SW J explained that Minimum Data Set (MDS) nurse was the person responsible to update the resident's medical diagnoses record. SW J reviewed R64's medical record and confirmed that her diagnoses record revealed the diagnoses of schizoaffective disorder bipolar type. SW J could not explain where this diagnoses had been obtained. In an interview on [DATE] at 03:01 p.m. Nursing Home Administrator (NHA) A explained that a residents diagnoses record is reviewed by the Interdisciplinary Team at morning meetings after new residents are admitted . NHA A could not answer why R64 had been given the diagnoses of schizoaffective disorder bipolar type on her diagnoses record or why R64's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], had been documented yes for Schizophrenia. NHA A explained that she would have to research R64's medial record and talk with staff to determine explanation. In an interview on [DATE] at 03:35 p.m. Regional Clinical Director (RCD) F explained that the diagnoses record for R64 was inaccurate for the diagnoses of schizoaffective disorder bipolar type and should have been given the diagnoses of bipolar disorder. RCD F explained that the computerized system automatically list schizoaffective disorder bipolar type when someone types in the diagnoses of bipolar disorder and staff would have needed to manually change the entered diagnoses. RCD F explained that R64's diagnoses record would need to be corrected and R64's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], Section I-Active Diagnoses would need to be corrected. Resident #89 (R89) (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed R89 was admitted [DATE] with diagnoses that included type 2 diabetes, chronic obstruction pulmonary disease (COPD), alcohol abuse, chronic pain, major depression, gastro-esophageal reflux, hypertension, protein-calorie malnutrition, delirium (confused thinking), altered mental status, insomnia, plural effusion (a buildup of fluid between tissues that line the lungs), anemia (low number of red blood cells), abdominal aortic aneurysm, and lung cancer. R89 was discharged from the facility [DATE]. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R89 had a Brief Interview of Mental Status (BIMS) of 11(mildly impaired cognition) out of 15. Review of R89's medical record revealed a Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] revealed section A0310 Type of Assessment, subsection F. Entry/discharge reporting was documented as 12. Death in Facility. Review of R89's medical record progress notes revealed [DATE] 17:11 (05:11 p.m.) eMar (electronic Medication Administration Record)-Medication Administration Note, Note text: In hospital. No other progress note demonstrated that R89 had returned to the facility. In an interview on [DATE] at 12:58 p.m. Regional Clinical Director (RCD) F explained that R89 had been transferred to a physician office for a routine visit. RCD F explained that R89 became lethargic and had an altered mental status and was sent to the emergency room for evaluation. RCD F provided hospital records that demonstrated that R89 died in emergency department [DATE]. Review of the Resident Assessment Instrument (RAI) manual pg. ,d+[DATE] Leave of absence (LOA) stated hospital observation stay less than 24 hours and the hospital does not admit resident would be coded as a facility Death. In an interview on [DATE] at 01:30 p.m. Regional Clinical Director (RCD) F explained that R89's Minimum Dat Set (MDS) with an Assessment Reference Date (ARD) of [DATE] should have been coded 10. Discharge-return anticipated. RCD F demonstrated that the facility corrected the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview, and record review the facility failed to develop and implement comprehensive resident-centered care plans for one out of 18 residents (R67), resulting in unmet care needs including restorative therapy within six months of right total shoulder replacement. Findings: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R67 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included urinary tract infection, multiple sclerosis(chronic disease of the central nervous system that causes muscle weakness and vision changes), and anxiety disorder. The MDS reflected R67 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact, and she required one person assist with transfers, ambulation and toileting. During an observation and interview on 1/02/25 at 11:42 AM, R67 was laying in bed and appeared able to answer questions without difficulty. R67 reported had recent right shoulder replacement July 2024 with very limited range of motion and eight out of ten on pain scale and difficulty sleeping. R67 reported was unable to lift right arm off the bed from laying position more than two inches and demonstrated. R67 reported had received therapy services on admission but had to discontinue related to insurance. R67 reported physician services talked about adding medication about two weeks prior but had not heard anything yet. During an interview on 1/06/25 at 11:21 AM, Therapy Director(TD) H reported R67 was not currently on therapy service related to insurance. TD H reported on admission R67 received both Occupational Therapy and Physical Therapy and was discharged from services 11/19/24. During an interview on 1/06/25 at 12:28 PM, TD H reported when R67 was discharged from services on 11/19/24 therapy completed recommendation for restorative therapy and would provide evidence. Review of R67 Electronic Medical Record(EMR), dated 10/25/24 through current(1/6/25), including Care Plans, reflected no evidence that R67 had ordered/received restorative therapy between 11/19/24 and 1/6/25. Continued review of R67 EMR reflected no evidence that R67 had recent right total shoulder replacement diagnosis including the MDS or Care Plans. During an interview on 1/06/25 at 12:40 PM, Director of Nursing(DON) B reported would expect therapy to recommend restorative therapy if needed and communicate to nursing and would expect restorative therapy to be on resident Care Plans and Kardex. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 1/06/25 at 1:05 PM, TM H provided R67 restorative referral, dated 11/25/24, signed and dated by two therapy staff and nursing signature line was blank. TM H reported process included that therapy would completed forms and he physically handed to the DON B to make sure nursing receives them. Review of R67, Restorative Referral form, dated 11/25/24, included R67 was a fall risk and was marked to have range of motion 2 time daily for upper extremities, Participate in ADL's(dressing/grooming) 2 times daily and ambulate two times daily with one person physical assist 2 wheel walker. During an interview on 1/6/25 at 1:25 PM, DON B reported was just provided R67 Restorative Therapy Referral today and was instructed by support staff that it was her responsibility to add to R67 plan of care including orders and care plans. DON B reported had been in position for over six months. DON B verified R67 did not have orders for Restorative therapy and had not been receiving between 11/25/24 and current date and should have been. DON B reported did not recall receiving R67 Restorative Referral 11/25/24. DON B reported facility was in the process of auditing past several months of restorative therapy referrals for compliance related to surveyor investigation.

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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** 27446 Based on observation, interview, and record review the facility failed to ensure for one out of 18 residents (Resident #41) care plan was revised as needed for changes in care needs. Findings Included: Review of R41's electronic medical record (EMR) revealed R41 was admitted to the facility on [DATE]. Record review of a wound evaluation dated 12/27/2024, revealed R41 had moisture associated skin damage (MASD) incontinence associate damage (IAD) to the sacrum (bone at the base of the spine) area. The MASD was documented to have developed in the facility. Further review of the wound evaluation dated 12/27/2024, revealed the interventions in place were a heel suspension/protection device, mattress with pump, positioning wedge, and a turning/repositioning program. Record review of a care plan in place for, Skin management initiated on 2/11/2024 and last revised on 9/26/2024 revealed, R41 was at risk for skin breakdown with one reason being from incontinence. The care plan had not been revised since 10/9/2024. The care plan was not revised to include R41's MASD/IAD issue, nor were the care plan interventions revised to include the positioning wedge and the turning/repositioning program. In an observation on 1/03/2025 at 9:26 AM, of R41's MASD/IAD area revealed three skin areas that were open skin area. In an interview on 1/03/2025 at 9:59 AM, Registered Nurse (RN) T, who was the wound nurse, stated, when a resident was identified to have any skin breakdown the one of the nurses would notified her, and the nurse would do the initial skin assessment. RN T said the assessment would go to the unit manager UM who would revise the resident's care plan. RN T said if she was in the facility at the time a resident had a new skin wounds then she would revised the resident's care plans.

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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** 32064 Based on interview and record review, the facility failed to ensure diagnostic practices met professional standards for two (R64 and R66) of five reviewed. Findings include: Resident #66 (R66) Review of the medical record revealed R66 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder. The MDS with an Assessment Reference Date (ARD) of 12/5/24 revealed R66 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Preadmission Screening/Annual Resident Review (PASARR) Level I Screening revealed no mention that R66 had a diagnosis of schizophrenia. Review of R66's diagnosis list revealed a diagnosis of schizophrenia was added on 11/29/24. Review of the MDS with an ARD of 12/5/24 revealed R66 was coded with a diagnosis of schizophrenia. Review of behavioral services note dated 12/19/24 revealed no mention that R66 had a diagnosis of schizophrenia. In an interview on 01/03/25 at 9:15 AM, Social Work Director (SWD) J reported R66 had a diagnosis of bipolar disorder. SWD J reported they were not sure why R66 had a diagnosis of schizophrenia listed in their medical record. Further information was requested regarding the diagnosis of schizophrenia which was not received prior to the survey exit. In an interview on 01/03/25 at 11:57 AM, Unit Manager (UM) K reported they did not know why R66 had a diagnosis of schizophrenia listed in their medical record or why it was coded on the MDS. further information was requested regarding the diagnosis of schizophrenia which was not received prior to the survey exit. In an interview on 01/03/25 at 3:25 PM, Regional Clinical Director (RCD) F reported R66's diagnosis of schizophrenia was inaccurate. 45038 Resident #64 (R64) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed R64 was admitted [DATE] with diagnoses that included peripheral vascular disease (PVD), type 2 diabetes mellitus, atherosclerotic heart disease (buildup of cholesterol plaque in artery walls), hypertension, history of heart attack, depression, osteoarthritis (type of arthritis that occurs when flexible tissue at the end of bones wears down) bilateral hips, asthma, and schizoaffective disorder bipolar type. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/25/2024, revealed R64 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. During observation and interview on 01/02/2025 at 01:36 p.m. R64 was observed lying down in bed. R64 explained that she has stayed at the facility several different times and that after the previous stay she was discharged home. R64 explained that she recently returned to the facility after a hospital stay. Review of R64's medical record revealed the most recent Minimum Dat Set (MDS), with an Assessment Reference Date (ARD) of 12/25/2024, revealed section I-Active Diagnoses, subsection 15900-Bipolar had been document no and subsection I6000- Schizophrenia, had been documented as yes. Review of R64's medical diagnoses record revealed the diagnoses of schizoaffective disorder bipolar type, which had been added to the diagnoses record on 12/19/2024. Review of R64's hospital discharge records, dated 12/19/2024 did not demonstrate a discharge diagnoses of schizoaffective disorder bipolar type. Review of R64's Preadmission Screening (PAS) Annual Resident Review (ARR), hospital exemption discharge date d 12/18/2024, revealed yes-the person has a current diagnosis of mental illness, yes-the person has received treatment for mental illness, yes-the person has routinely received one or more prescribed antipsychotic or antidepressant medication within the last 14 days. The same PASARR, dated 12/18/2024 revealed documentation that stated, explain any yes - bipolar . In an interview on 01/03/2025 at 02:54 p.m. Social Worker (SW) J explained that she is responsible to review that residents that are receiving psychotropic medication to ensure that they have the appropriate diagnoses for the use of that type of medication. SW J explained that she is not responsible to verify the diagnoses with previous hospital records and only verifies those diagnoses by reviewing the resident's diagnoses record in the chart. SW J explained that Minimum Data Set (MDS) nurse was the person responsible to update the resident's medical diagnoses record. SW J reviewed R64's medical record and confirmed that her diagnoses record revealed the diagnoses of schizoaffective disorder bipolar type. SW J could not explain where this diagnoses had been obtained. In an interview on 01/03/2025 at 03:01 p.m. Nursing Home Administrator (NHA) A explained that a residents diagnoses record is reviewed by the Interdisciplinary Team at morning meetings after new residents are admitted . NHA A could not answer why R64 had been given the diagnoses of schizoaffective disorder bipolar type on her diagnoses record or why R64's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/25/2024, had been documented yes for Schizophrenia. NHA A explained that she would have to research R64's medial record and talk with staff to determine explanation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/03/2025 at 03:35 p.m. Regional Clinical Director (RCD) F explained that the diagnoses record for R64 was inaccurate for the diagnoses of schizoaffective disorder bipolar type and should have been given the diagnoses of bipolar disorder. RCD F explained that the computerized system automatically list schizoaffective disorder bipolar type when someone types in the diagnoses of bipolar disorder and staff would have needed to manually change the entered diagnoses. RCD F explained that R64's diagnoses record would need to be corrected and R64's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/25/2024, Section I-Active Diagnoses would need to be corrected.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based observation, interview and record review the facility failed to provide daily oral hygiene for one resident (Resident #5) of two residents reviewed for activities of daily living. Findings include: Review of Resident #5's (R5) clinical record, including the Minimum Data Set (MDS) dated [DATE], R5 had diagnoses that included anxiety and depression and scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Review of R5's Activities of Daily Living (ADL) care plan dated 11/18/22 reflected R5 needed assistance with oral hygiene which was to be done every shift and as needed. Review of R5's kardex (a guide for Certified Nursing Assistants) reflected oral hygiene was to be done every shift and as needed. On 01/02/25 at 11:02 AM, R5 was observed in the Activity room, R5's bottom teeth were observed to be caked with debris and R5 had severe halitosis. On 01/03/25 at 09:17 AM, R5 was observed in main dining room and again at the Resident Council Meeting at 11:00 AM. Both observations R5 had caked debris on bottom teeth and gum line. On 01/03/25 10:15 AM, during an interview with Certified Nursing Assistant (CNA) D she reported the midnight shift was responsible for getting R5 up and completing morning care. CNA D reported R5 was cooperative with care and did not refuse ADL assistance. On at 01/06/25 09:28 AM R5 was observed in the activity room, caked on debris was observed on R5's lower teeth. On 01/06/25 at 09:57 AM, during an interview with Registered Nurse/Unit Manager (RN/UM) C, reported R5's lower teeth were the natural teeth and R5 was due to be seen by the dentist the near future. When queried what the expectation was for the CNA's to provide oral care, RN/UM C stated They have to see dentist first, they make recommendations. RN/UM C then stated after all meals, at night and as needed. RN/UM C offered no explanation for R5's lack of oral care. On 01/06/25 at 10:41 AM during an Interview with R5 (bottom teeth still observed with debris along with strong halitosis) when queried if she was receiving the care needed, R5 stated Not brushing my teeth, I have been trying to get them to get me [name redacted-mouth wash] and toothpaste- I have been asking and asking and they say will and it never shows up. R5 reported being out of these items for at least two weeks, R5 further stated the bottom teeth had a partial and there was no pill to soak them in overnight. R5 stated staff do not remove the partial and her teeth have not been brushed in weeks. I don't like it! R5 stated she had requested staff to assist her with brushing her teeth and was told they don't have time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review reflected R5 was seen by the dentist on 10/31/24 and the consult reflected R5 had calculus and plaque build up. R5 was seen again by the dentist on 12/09/24, this consult revealed scaling was completed by hand and moderate calculus was found along with heavy plaque. Recommendations-assistance from staff for daily hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review the facility failed to follow a physician's order, and appropriately position two residents, (R6 and R67), of 18 reviewed for quality of care, resulting in increased likelihood of unmet care needs and potential for worsening of contractors. Findings include: Resident #67(R67) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R67 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included urinary tract infection, multiple sclerosis(chronic disease of the central nervous system that causes muscle weakness and vision changes), and anxiety disorder. The MDS reflected R67 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact, and she required one person assist with transfers, ambulation and toileting. During an observation and interview on 1/02/25 at 11:42 AM, R67 was laying in bed and appeared able to answer questions without difficulty. R67 reported had recent right shoulder replacement July 2024 with very limited range of motion and eight out of ten on pain scale and difficulty sleeping. R67 reported was unable to lift right arm off the bed from laying position more than two inches and demonstrated. R67 reported had received therapy services on admission but had to discontinue related to insurance. R67 reported physician services talked about adding medication about two weeks prior but had not heard anything yet. Review of R67 Psych Consult, dated 12/19/24, reflected recommendations to start Trazodone 25mg every night for adjustment insomnia. Continued Review of R67 Electronic Medical Record(EMR), dated 12/19/24 through 1/3/25 reflected no mention R67's consult was discussed with primary care physician or physician orders for Trazadone. During an interview on 1/3/24 4:55 pm, Director of Nursing (DON) B reported process for consult visits including Unit Managers were expected to review visit notes and consult recommendations and contact physician, and add orders to EMR. During an interview on 1/06/25 at 10:36 AM, Unit Manager(UM) V reported if residents were seen by Psych Services the facility Social Worker would review consult notes and contact Unit Manager or DON to address the recommendations. During an interview on 1/06/25 at 10:45 AM, Social Worker (SW) J reported facility psych services see residents then she reviews notes and notifies unit managers to make adjustments in orders if needed. SW J reported did not recall psych service consult visit for R67 but facility physician usually follow psych service recommendations. SW J reported would follow up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 1/06/25 at 12:57 PM, SW J verified physician order for Trazodone was not addressed after R67 psych group consult and was physician order was added today for Trazodone 25 mg every night for sleep. SW J reported that R67 consult visit was not addressed timely and planed to review all consults to verify other residents were audited. 27306 Resident #6 (R6) Review of the clinical record including the Minimum Data Set (MDS) with an assessment reference date of 12/22/24 reflected Resident # 6 (R6) was admitted to the facility on [DATE] with diagnoses that included cerebral infarction with left sided hemiparesis and hemiplegia. R6 scored 00 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). On 01/02/25 10:50 AM R6 was observed sitting in a high back wheelchair at nurses station - foot rests were attached to the wheelchair but R6's feet did not reach the foot rests and R6's feet/legs were left dangling. R6 was again observed in the same wheelchair and same position in the Tea dining room during the noon meal. On 01/03/25 at 08:40 AM, R6 was observed in Tea dining room sitting in the high back wheelchair feet dangling foot rests in place but R6's feet not on foot rests. At 8:49 R6 was observed be removed from the dining room by staff with feet/legs dangling. On 01/03/25 at 10:19 AM, R6 was observed sitting in the high back wheelchair at the nurses station outside activity room, foot rests in place, however R6's feet were still observed dangling. Same observation was made on the same date at 11:00 AM, 12:37 PM and again in the Activity room at 3:19 PM. On 1/06/25 at 08:38 AM, R6 was observed in Tea dining room eating breakfast same high back wheelchair with foot rests in place and R6's feet not reaching the foot rests and feet observed dangling. On 01/06/25 at 09:50 AM, during an interview with Registered Nurse/Unit Manager (RN/UM) C, reported she never noticed R6's feet did not touch foot rests. RN/UM C elaborated that the facility's therapy department assessed residents for their wheelchairs and therapy was responsible for issuing R6 the current wheelchair. A request was made at that time of therapy's assessment/fitting of R6's wheelchair, which was not provided by the end of the survey.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34705 Based on observation, interview and record review, the facility failed to provide restorative services for one residents (R67) of one residents reviewed for restorative care, resulting in the potential for all residents with Restorative Referrals, facility census 77, to decline in their current highest functioning level losing their independence and leading to withdrawal, depression and complications of immobility. Findings Include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R67 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included urinary tract infection, multiple sclerosis(chronic disease of the central nervous system that causes muscle weakness and vision changes), and anxiety disorder. The MDS reflected R67 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact, and she required one person assist with transfers, ambulation and toileting. During an observation and interview on 1/02/25 at 11:42 AM, R67 was laying in bed and appeared able to answer questions without difficulty. R67 reported had recent right shoulder replacement July 2024 with very limited range of motion and eight out of ten on pain scale and difficulty sleeping. R67 reported was unable to lift right arm off the bed from laying position more than two inches and demonstrated. R67 reported had received therapy services on admission but had to discontinue related to insurance. R67 reported physician services talked about adding medication about two weeks prior but had not heard anything yet. Review of the Hospital Orthopedic Surgery Progress Notes, dated 7/19/24, reflected R67 had right reverse total should replacement on 7/18/24. Review of R67 Hospital Occupational Therapy Progress Note, dated 10/24/24, reflected section for range of motion/strength/sensory that reflected, Guarding of the RUE[right upper extremity] at elbow and shoulder due to hx of total shoulder arthroplasty with greater tuberosity repair on 7/18/24 . Review of R67 Electronic Medical Record(EMR), dated 10/25/24 through current(1/6/25), reflected no evidence that R67 had recent right total shoulder replacement diagnosis including the MDS or Care Plans. Continued review of the EMR reflected Physician Progress Note, dated 12/13/24, that reflected, Patient with acute pain secondary to right humerus fracture and pain better managed with Norco. Following and awaiting surgical intervention or [NAME] follow up . During an interview on 1/06/25 at 11:21 AM, Therapy Director(TD) H reported R67 was not currently on therapy service related to insurance. TD H reported on admission R67 received both Occupational Therapy and Physical Therapy and was discharged from services 11/19/24. TD H verified R67 had prior history of right shoulder replacement in July 2024. During an interview on 1/06/25 at 12:28 PM, TD H reported when R67 was discharged from services on 11/19/24 therapy completed recommendation for restorative therapy and would provide evidence. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R67 Electronic Medical Record(EMR), dated 10/25/24 through current(1/6/25), including Care Plans, reflected no evidence that R67 had ordered/received restorative therapy between 11/19/24 and 1/6/25. Continued review of R67 EMR reflected no evidence that R67 had recent right total shoulder replacement diagnosis including the MDS or Care Plans. During an interview on 1/06/25 at 12:40 PM, Director of Nursing(DON) B reported would expect therapy to recommend restorative therapy if needed and communicate to nursing and would expect restorative therapy to be on resident Care Plans and Kardex. During an interview and record review on 1/06/25 at 1:05 PM, TM H provided R67 restorative referral, dated 11/25/24, signed and dated by two therapy staff and nursing signature line was blank. TM H reported process included that therapy would completed forms and he physically handed to the DON B to make sure nursing receives them. Review of R67, Restorative Referral form, dated 11/25/24, included R67 was a fall risk and was marked to have range of motion 2 time daily for upper extremities, Participate in ADL's (dressing/grooming) 2 times daily and ambulate two times daily with one person physical assist 2 wheel walker. During an interview on 1/6/25 at 1:25 PM, DON B reported was just provided R67 Restorative Therapy Referral today and was instructed by support staff that it was her responsibility to add to R67 plan of care including orders and care plans. DON B reported was not aware prior to today that is was her responsible to add restorative therapy orders. DON B reported had been in position for over six months. DON B verified R67 did not have orders for Restorative therapy and had not been receiving between 11/25/24 and current date and should have been. DON B reported did not recall receiving R67 Restorative Referral 11/25/24. DON B reported facility was in the process of auditing past several months of restorative therapy referrals for compliance related to surveyor investigation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on interview and record review the facility failed to ensure for two of five residents (Resident 41 and 66) pharmacy medication recommendations were followed-up on by the Physician. Findings Included: Resident #41: Per R41's electronic medical record (EMR) R41 was admitted to the facility on [DATE]. Diagnosis included a fracture of the sacrum (bone at the base of the spine). Review of R41's Physician's orders revealed that on 10/5/2024 Tylenol was ordered as needed for pain, Oxycodone was ordered on 10/7/2024 for pain, and Tramadol was ordered on 11/4/2024 for pain. Review of R41's progress notes revealed a Pharmacy Recommendation dated 11/28/2024, of, PHARMACIST RECOMMENDS:: Patient is on three pain medications: Oxycodone, Tramadol and acetaminophen. Which is to be used for mild pain? _____ Which is to be used for moderate pain? _____ Which is to be used for severe pain? _____ RESPONSE TO RECOMMENDATION: FOLLOW-UP REQUIRED:: yes Review of R41's EMR revealed no Physician follow-up on the Pharmacy Recommendation dated 11/28/2024, on order to identify each of the three medication's use for each level of pain. In an interview on 1/03/2025, at 12:49 PM, the Director of Nursing (DON) B stated that the Pharmacy Recommendation dated 11/28/2024, was for the Physician to document which medication was for mild, moderate, or severe pain, however DON B stated that the Physician follow-up was never done for the Pharmacy Recommendation dated 11/28/24. 32064 Resident # 66 (R66) Review of the medical record revealed R66 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease (GERD), diabetes, and chronic obstructive pulmonary disease (COPD). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Order dated 11/9/24 revealed an order for Metformin HCl (used to treat high blood sugar) 1000 mg two times per day related to type 2 diabetes. The medication was scheduled to be administered between 7:00 AM and 10:00 AM and again between 7:00 PM and 10:00 PM. Review of the Physician's Order dated 11/10/24 revealed an order for glycopyrrolate 1 milligram (mg) in the morning related to COPD exacerbation. Glycopyrrolate is a medication used to treat stomach ulcers, not COPD. Review of the Pharmacy Recommendations dated 11/12/24, revealed recommendations to 1) provide a diagnosis for glycopyrrolate, and 2) Metformin was recommended to to be given with meals; consider adjusting the medication time to comply. Review of the medical record revealed an appropriate diagnosis was never added to glycopyrrolate and the timing of Metformin was not adjusted. The medical record did not include documentation from the physician as to why the recommendations were not implemented. In an interview on 01/03/25 at 11:47 AM, Director of Nursing (DON) B reported it appeared R66's pharmacy recommendations from 11/12/24 were not addressed. On 01/03/25 at 12:12 PM, DON B and Regional Clinical Director (RCD) F reported the facility had 30 days to act on pharmacy recommendations, but R66 was in the hospital from 11/26/24 to 11/29/24. RCD F reported the pharmacy review dated 12/5/24 revealed no recommendations and that was the review the facility would have considered when R66 returned from the hospital. Review of the Medication Review and Reporting policy dated 9/18 revealed Recommendations shall be acted upon within 30 calendar days.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to ensure medications were administered within parameters for one (R66) and the appropriate antibiotic was administered for one (R45) of five reviewed. Findings include: Resident #66 (R66) Review of the medical record revealed R66 was admitted to the facility on [DATE] with a diagnosis of hypertension (high blood pressure). Review of Physician's Order dated 11/10/24 revealed an order for Lisinopril (used to treat high blood pressure) 2.5 milligrams (mg) in the morning. On 11/26/24 parameters were added to the order to hold the medication for a systolic blood pressure less than 110. Review of the Medication Administration Record (MAR) revealed Lisinopril 2.5 mg was administered on 12/14/24, 12/22/24, and 12/25/24 when R66's systolic blood pressure was 108. In an interview on 01/03/25 at 11:57 AM, Unit Manager (UM) K reported R66 had a fall, and parameters were added to hold the lisinopril if R66's systolic blood pressure was less than 110. UM K reported R66's Lisinopril was administered on 12/14/24, 12/22/24, and 12/25/24 when it should have been held. UM K was not able to explain why the medication was administered when it should have been held per orders. 45038 Resident #45 (R45) Review of the medical record revealed R45 was admitted [DATE] with diagnoses that included subarachnoid hemorrhage (brain bleed-stroke), lymphedema (swelling, most often in legs and arms, caused by a lymphatic system blockage), hyponatremia (low sodium), hypertension, type 2 diabetes, dysphasia (difficulty swallowing), anemia (low red blood cells), osteoporosis (condition bones become weak and brittle), polyosteioarthritis (arthritis affecting at least five joints), gastro-esophageal reflux, hyperlipidemia (high fat content in blood), claustrophobia (fear of confined spaces), constipation, and urinary tract infection. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/10/2024, revealed R45 had a Brief Interview of Mental Status (BIMS) of 00 (indicates the most sever level of cognitive impairment) out of 15. During observation and interview on 01/02/2025 at 11:21 a.m. R45 was observed lying down in bed and appeared well groomed. R45 did not respond to verbal stimulation. R45's husband E was observed sitting in a chair at the side of R45's bed. R45's husband E explained that R45 could not respond to verbal stimulation as she had recently been tested for a urinary tract infection but explained he did not know the results of the urinary test. R45's husband E explained that he was at the facility frequently and assisted with personal grooming and incontinent care of R45. (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 R45's medical record on 01/02/2025 at 12:18 p.m. demonstrated a diagnosis of urinary tract infection that revealed a creation date of 12/26/2024. Review of 45's Order Summary Report revealed Bactrim DS oral Tablet 800-160MG (Milligrams) (Sulfamethoxazole-Trimethoprim) Give 1 tablet VIA (by) Peg-tube two times per day for urinary tract infection, with an order date of 12/26/2024 and a start date of 12/27/2024. Review of R45's medical record demonstrated that on 12/26/2024 at 10:20 pm This write was called into resident's room per CNA (Certified Nurse Aide) at approx. 1700 (07:00 p.m.) hours. Husband was at bedside and brought to this writer's attention that (name of resident) had dime size blood clots in her brief, and CNA was providing peri-care and was wiping clots that were coming from her vaginal area. Clots were dark red in color, and this writer did notify hospice. Hospice did contact this writer back and did dispatch a nurse onto site to see (name of resident). Nurse did arrive at approx. 1830 (06:30 p.m.) and did witness the clots in her brief. She did speak with this writer, and she did order Bactrim DS twice daily x7 days for UTI (urinary tract infection). First dose of antibiotic was started this evening and given via peg tube Review of documentation from laboratory services for R45 demonstrated that a urinalysis was collected on 12/27/27/2024 at 10:07 a.m. The result form the urinalysis was printed by the facility 12/28/2024 at 02:01 a. m. The urinalysis results demonstrated WBC (white blood cells) greater than 100 (should be none) and RBC (red blood cells) greater than 100 (should be none), blood -large amount (should be none), and large amount of leukocyte esterase (should be none). The same urinalysis demonstrated that a urine culture was in process. Review of R45's urine culture and sensitivity collected 12/27/2024 at 10:07 a.m. and reported to the facility on [DATE] at 03:51 p.m. Demonstrated 50,000-100,00 col/ml Proteus mirabilis and >100K col/ml Enterococcus faecalis. The same susceptibility report demonstrated Trimethoprim-Sulfamethoxazole was resistant. Review of R45's medical record on 01/02/2025 at 04:12 p.m. revealed that Bactrim DS oral Tablet 800-160MG (Milligrams) (Sulfamethoxazole-Trimethoprim) Give 1 tablet VIA (by) Peg-tube two times per day for urinary tract infection had been discontinued on 01/02/2025 at 3:42 p.m. R45's medical record also demonstrated a new antibiotic order entered 01/02/2025 Augmentin Oral Tablet 500-125 mg give one tablet via pet tube two times a day for UTI for 5 days. Review of R45's January Medication Administration Record revealed the last dose of Bactrim DS was given on 01/02/2025, in the morning, and the first dose of Augmentin was given 01/02/2025, in the evening. In an interview on 01/02/2025 at 04:31 p.m. Clinical Care Coordinator (CCC) K explained that she had called the physician assistant to have R45's antibiotic changed because the Bactrim DS was not appropriate to treat the organism identified on R45's urine culture and sensitivity results. CCC K also explained that she received an order to change the antibiotic to Augmentin as the urinary organisms were susceptible according to R45's urine culture and sensitivity results. CCC K explained that the results of R45's urine culture and sensitivity report was reported to the facility 12/31/24 but could not explain why the antibiotic had not been changed at that time and stated that this was the first day she had returned to work after the holiday. When asked to explain why she had noticed these results so late in the day, she responded that this that time was the first chance she had to review laboratory orders. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/03/2025 at 09:06 a.m. Corporate Director of Infection Control L explained that R45's hospice provider had requested that a urine analysis, and culture if indicated, be completed for blood in R45's urine. Corporate Director of Infection Control L was asked what other signs or symptoms had R45 exhibited, she responded only bleeding. When asked what criteria was used by the facility for screening of possible infections, she explained that it was the expectation that the facility follow the Mcgeer Criteria. Corporate Director of Infection Control L also explained that if the Mcgeer Criteria was not followed a risk benefit analysis needed to be completed by the medical provider. Corporate Director of Infection Control L could not locate a risk benefit analysis for R45 at that time. Corporate Director of Infection Control L also explained that it was the facility expectation that the nursing staff notify the medical provider of the urinary test results when the results are returned and that appropriate action be taken, for example change to the appropriate antibiotic. Corporate Director of Infection Control L could not answer why R45's antibiotic was not changed until 01/02/2025 even though urine culture and sensitivity results were received by the facility on 12/31/2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 Based on observation, interview and record review the facility failed to ensure a gradual dose reduction (GDR) was attempted for one of five residents (Resident #47) in order to reduce the use a psychotropic. Findings Included: Review of Resident #47's electronic medical record (EMR) revealed R47 was admitted to the facility on [DATE]. Review of R47's medication administration record (MAR) for the month of April 2024, revealed R47 was ordered to received Prozac (a psychotropic medication) 40 mg one capsule in the morning for depression and bipolar disorder (a mental disorder of manic swings and depression). Review of behavioral notes dated 8/13/24 revealed Prozac will be attempted to be GDR and will be noted in R47's chart. Review of behavioral health services Physician's notes dated 8/13/2024, revealed R47's psychotropic medication were reviewed, and the Prozac was documented as, Prozac 40 mg (milligrams) capsule LAST GDR CONSIDERATION .8/13/2024, GDR will be Attempted: GDR will attempted and will be noted in resident's chart. Record review of R47's EMR revealed no GDR was order, and no GDR was attempted. Review of R47's Physician's order revealed R47's last Physician order for Prozac was on 4/8/2024 and the Prozac was started on 4/9/2024. As of 1/6/2025 R47's Prozac had not changed and was still being administered at 40 mg one capsule in the morning. Further review of R47's EMR revealed R47 had not been seen by behavioral health services since 8/13/2024 In an interview on 1/06/2025 at 9:30 AM, Social Worker SW (J) acknowledged that R47 remained on 40 mg of Prozac, and that the GDR had not been attempted, and also confirmed that R47 had not been seen by behavioral health services since then 8/13/2024, and stated that she did not know why. SW J said R47 should have been seen by behavioral health services. SW J was observed to add R47 to the behavioral health services list of residents to be seen on the next visit. SW J also stated that R47 should have been seen monthly by behavioral health services.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to ensure timely dental services to obtain dentures for one (R7) of one resident reviewed. Findings include: Review of the medical record revealed R7 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, diabetes and dementia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/7/24 revealed R7 scored 6 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and received hospice services. Review of the MDS with an ARD of 12/14/24 revealed R7 did not have a broken or loosely fitting full or partial denture. The MDS assessments with ARDs of 3/12/24, 6/7/24, and 9/7/24, and 12/7/24 revealed R7 had a broken or loosely fitting full or partial denture. On 01/02/25 at 11:53 AM, R7 was observed sitting in a Broda chair at a dining room table with a family member. Family Member R reported R7's upper denture had been broken since April and the bottom denture had been lost. Family Member R reported they thought the facility had been working on replacing the dentures, but the dentures had not been replaced yet. On 01/03/25 at 8:07 AM, Hospice Certified Nursing Assistant (CNA) S reported R7's top denture was broken, and the bottom denture was lost. Review of the Social Service Note dated 2/15/2024 revealed This writer contacted [dental service provider] because this resident's dentures are broken. [Dental service provider] stated that this resident has not been seen by them and they will need to see him prior to fixing his dentures. A referral with signed consent was faxed to [dental service provider] this morning for this resident. Review of the Dental Note dated 2/23/24 revealed Patient lost tooth #7 in his upper denture and broke his lower denture. He did not know where the lower denture was. Nursing station said they have the lower denture at the social workers office. He is on a soft diet until they are repaired. Review of the Social Service Note dated 3/25/24 revealed This writer spoke with [dental service provider] regarding this resident's broken dentures. This resident did not receive his dentures from [dental service provider] so they are not able to repair them. We do not currently have a dental visit date with [dental service provider] as we are waiting on [dental service provider] to contact this writer with the next visit date. This resident has been added to the visit list. Review of the Nutritional Note dated 4/29/2024 09:21 revealed Has dentures; new bottoms made this month, top missing, waiting on replacement. Review of the Dental Note dated 10/11/24 revealed Denture Step #1: ULCD [upper and lower complete denture] (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preliminary upper and lower PVS [polyvinyl soloxane] impressions taken with stock trays. Patient tolerated impressions well. NV: Final impressions. The note revealed Denture Step #2 was dated for 11/1/24. R7 did not have any further dental notes in their medical record. In an interview on 01/03/25 at 09:15 AM, Social Work Director (SWD) J reported the facility recently changed dental service providers and the new provider was in the facility in December. SWD J reported they were unsure how often the dentist visited the facility. SWD J reported the previous dentist saw one resident, who was not R7, on 12/27 because they were in the process of fixing their dentures. SWD J reported the previous dentist was not in the process of repairing or replacing dentures for any other residents. SWD J reported the new dentist did not see R7 in December. When asked for the list of residents to be seen at the next dentist visit, SWD J provided one resident name which was not R7. SWD J reported R7 was always on the list to see the dentist and could not explain why R7 was not seen last month. When asked about R7's dentures, SWD J reported R7 had been without dentures for quite a while. SWD J reported the previous dental provider took impressions for dentures, but it was their understanding that R7 was to see the new dental service provider for dentures.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 Based on observation, interview, and record review the facility failed to provide hot liquids at a palatable temperature to 4 of 5 residents in a group interview and one of one residents (R61). This deficient practice has the potential to result in decreased hydration consumption and potential for decreased satisfaction of living. Findings include: On 01/03/25 at 11:05 AM during the confidential group meeting, 4 of the 5 members reported the coffee was cold and this problem/complaint was ongoing. The group participants reported that while in the dining room you can see into the kitchen where 20 to 30 cups of coffee get poured and sit on the counter and then get placed on individual trays. The group reported there was a lid on the cups but it was to prevent spills not a thermal top and the poured coffee sits for approximately 30 minutes before it gets place on the food tray. Review of the Resident Council meeting minutes reflected residents complained of coffee temperatures being too cold on 7/23/24, 8/20/24 and 9/24/24 Review of the 12/17/24 minutes reflected no new concerns, It was explained to residents why a carafe cannot be used because of various {sic} temps. (no further explanation was documented as to why carafes cant be used.) On 01/06/25 at 09:14 AM, during an interview with NHAA reported the Resident Council Members wanted coffee kept in a carafe kept on the Nursing units, NHA A stated that would solve the coffee temperature issue but it proposed a safety issue for the dementia residents and she had no intention on implementing that suggestion. When queried what was going to be implemented to solve the coffee temperature issue NHA A stated the Dietary Manager was taking care of the issue and NHA A would attempt to get documentation from the Dietary Manager as to what efforts have been made regarding the cold coffee complaints. No such documentation was provided by the exit date. 32064 Resident # 61 (R61) Review of the medical record revealed R61 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety, and depression. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/24 revealed R61 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R61's meal ticket revealed Serve fresh coffee out of machine in a 2 handled cup with lid. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/02/25 at 10:48 AM. R61 was observed sitting on the edge of their bed and reported they were the Resident Council President. R61 stated, All I want is a hot coffee. R61 reported the facility filled coffee cups first and by the time the meal tray was delivered to their room, the coffee was cold. R61 reported the concern with coffee temperature came up in resident council often and most of the residents agreed the coffee wasn't hot enough. R61 reported they now have a lid on their coffee, but that did not resolve the temperature issue. On 01/03/25 at 09:14 AM, Nursing Home Administrator (NHA) A reported they did not have any grievance/concern forms for R61, but there were some from resident council. All grievance/concern forms related to coffee temperatures from Resident Council was requested. NHA A provided an Assistance Form dated 6/19/24. Review of the Assistance Form dated 6/19/24 from resident council revealed Hot water isn't hot enough and the 100 hall is last, so the water is very cold. They also want soup without going in the dining room. The form revealed this was an ongoing issue. There was no mention of coffee. Resident Council Minutes dated 7/23/24 revealed WANT HOT COFFEE! [was underlined] Small carafes? Why can't the hot water from the kitchen go into a carafe? When they bring trays pour the coffee. Resident Council Minutes Dated 8/20/24 revealed Still issues w/coffee slopped on trays [and] cold. Resident Council Minutes dated 9/24/24 revealed carafe for coffee as new business. There was no Resident Council Meeting in October 2024. Resident Council Minutes dated 11/26/24 revealed Follow up .carafe cannot be temperature controlled. Resident Council Minutes dated 12/17/24 revealed It was explained to residents why a caraf [sic] cannot be used because of various temps. In an interview on 01/03/25 at 1:49 PM, Dietary Manager (DM) P reported they received concerns from resident council and recalled recent concerns regarding coffee being too cold. When asked what was being done to resolve the cold coffee concern, DM P reported there were a couple residents who were very boisterous about this. DM P reported those residents, including R61, got their coffee served out of the machine when their tray ticket came out. When asked about the process, DM P reported when the tray ticket came out, the coffee was poured, the tray and coffee were loaded on the cart, and once the cart was full, it was delivered to the unit. DM P reported tray carts held up to 18 trays and it could take approximately 10 to 15 minutes for trays to be delivered to the residents. DM P reported R61 was now using a two handled cup for their coffee because another resident told R61 that the coffee seemed hotter in that cup. DM P reported R61 still had concerns with cold coffee. DM P reported coffee temperatures were obtained in the kitchen with a goal of 160 to 170 degrees Fahrenheit. DM P reported they did not know the temperature of the coffee when it arrived to the residents because they have never obtained temperatures at that time. On 1/3/24 at 4:46 PM, NHA A reported the facility did not have a hot liquid policy. 45038 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation of meal service on 01/02/2025 at 11:29 a.m. Culinary Specialist Q was observed temping a cup of coffee. The cup of coffee was covered with plastic wrap. After temping the cup of coffee, Culinary Specialist Q instructed the dietary staff to dump out the four cups of coffee that were pre-poured and covered with a plastic film. Culinary Specialist Q explained that the staff should not pre pour the coffee before service but should obtain the coffee directly from the coffee machine and place the coffee cup on the resident's service food tray.